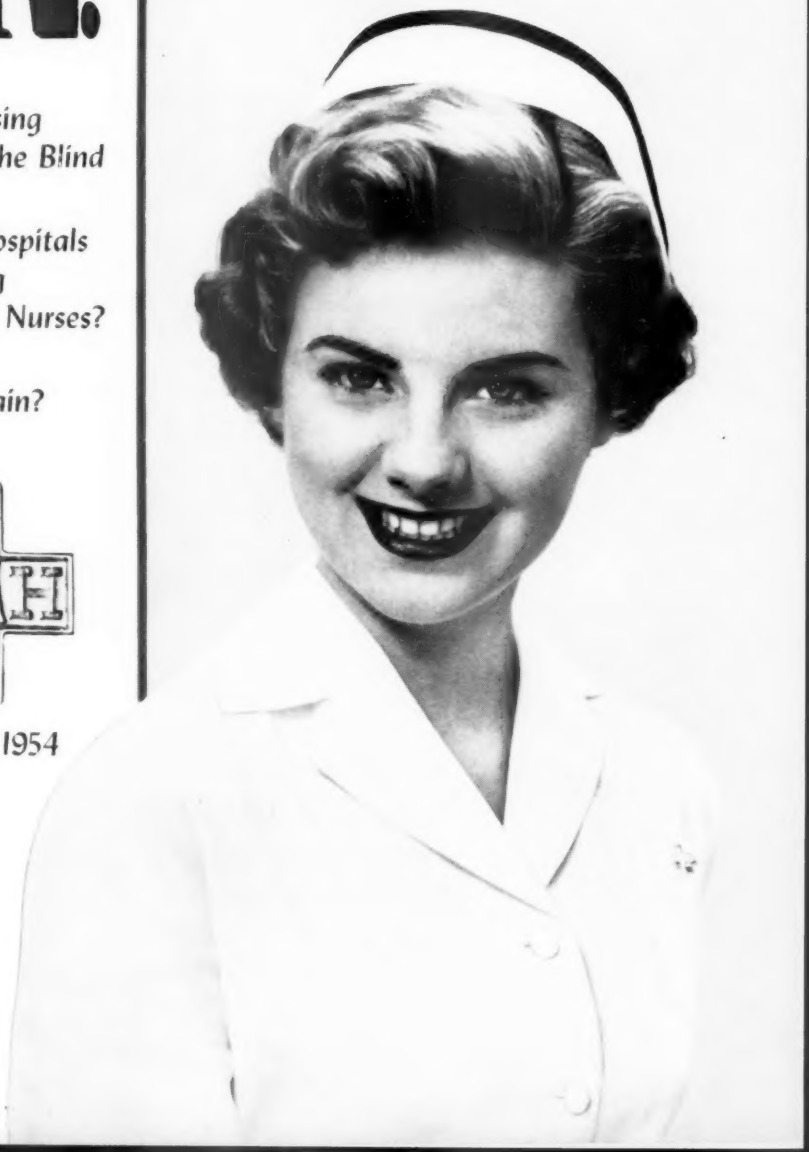
R.N.

a journal for nurses

- Home Nursing for the Blind
- Are Our Hospitals Exploiting Foreign Nurses?
- What Is Pain?

September 1954



R.N.

Contents

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Vol. 17, No. 9

BPA NBP

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Sincere Thanks

Dear Editor:

My sincere appreciation to you and your staff for the splendid support extended to the National Foundation for Infantile Paralysis during the past year.

The assistance and interest of the members of the nursing profession is an important contribution to the success of the programs financed by the March of Dimes. The wholehearted response of your readers contributed substantially to the success of the recent Vaccine Field Trial.

The eyes of the world were focused recently on the stand one lone woman was making in behalf of humanity. The site was a walled-in fortress on the other side of the world—before and after its surrender. Here a lone French nurse—the Angel of Dienbienphu—ministered to wounded men in that besieged volcano of war.

I wish I could for a moment direct the attention of the world to thousands of American nurses—some right in your communities—and many of whom I hope may be reading these words right now. Let me hail the work of these nurses who did so much to make the operational phase of the Polio Vaccine Field Trial an historic success.

I speak my thanks to all the nurses in the hundreds of cities, towns and villages who constituted an essential part of the professional teams that volunteered their services. I include, too, the many who stood ready to contribute their talents, if needed. Two hundred and seventeen areas, embracing several thousand communities, took part in the study. Interest and support came from nurses far beyond the immediate areas affected, for they know the importance of these studies. They knew that the project was endorsed and guided by scientists and motivated by sound medical principles.

Your army of volunteers represented registered nurses in a host of roles—those on hospital staffs, private duty, public health, school and industrial nurses, and those wonderful R.N.'s who rallied to the call by coming out of retirement for this job.

I salute you all, and thank you all —not only for myself, but for the medical and professional staffs at National Foundation headquarters and for our 3,100 chapters, whose

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BASIL O'CONNOR, PRESIDENT
NATIONAL FOUNDATION FOR
INFANTILE PARALYSIS

Human Worth

Dear Editor:

Dignity, self-esteem, a sense of human worth, are the God-given rights of every individual regardless of race, color, or creed. And we all know, of course, that it is only the person who has not a sense of his own worth who makes contemptuous remarks about persons of another race. It is particularly distressing, therefore, to see the word 'coons' appear in the casual remark of a nursing supervisor in the *D & C* letter, "Let's Speak With Dignity," [Feb., 1954].

R.N., CHICAGO, ILL.

Socially Unacceptable

Dear Editor:

For many years I have refrained from associating socially with nurses for the very reason mentioned in the article, "Are You Guilty of Talking Shop?" [Nov., 1954]. I have nothing against nurses, but I found my life was too unbalanced; the cultural aspect was lacking, simply because I associated only with those in the profession who knew little else but the job.

And why must nurses be so indiscreet in their conversation? Recently my husband and I spent a miserable

evening with two M.D.'s and two R.N.'s who actually made us blush with their medical, pseudo-sophisticated chatter.

I have found it good discipline not to even mention my professional background to new friends. The minute one mentions nursing to the layman, it seems the entire trend of the conversation is turned to "Why" – "How" – "My operation" – "Doctors." And all too frequently laymen expect nurses to diagnose their ailments for them.

Let the fur fly! These are thoughts that I've had for many years, even though I have never expressed them before.

R.N., CHICAGO, ILL.

"F" For Attendance

Dear Editor:

In a *D & C* letter [May, 1954], the executive secretary of District No. 5 of the Florida SNA says: "Perhaps on a national level sections are plausible but on a district level we feel they have tended to disunite our district."

Her problem, evidently, is akin to ours of the General Duty Section of District No. 13 of the New York SNA. We have, I believe, one of the largest general duty sections in the country, with a membership in the neighborhood of 567. Yet, for all of this, we have only about nine nurses who show enough interest to turn out for our section meetings. We have interesting programs and good discussions, and those members who attend our meetings seem to enjoy

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them as evidenced by their comments. Why then does such a small number show up? Is it due to apathy toward the problems of nursing or is it due to lack of time? I wonder.

Perhaps the answer lies in getting a place large enough to hold individual section meetings prior to the district meetings. I don't know if this is the answer, but I'm throwing it out as a possible solution.

Our organization is the tool whereby we may improve our common lot, and I would hate to see any further decline in the use of this tool.

BARNETTE KOCH, R.N.
NEW YORK, N.Y.

Surgery at Sea

Dear Editor:

As a nurse in the U.S. Navy, I was recently assigned to MSTS for duty aboard a ship in the Atlantic. On my second day at sea I, along with two other nurses, assisted with an emergency appendectomy. None of us had had any O.R. experience since our student days.

At the present time a transport has only one nurse and often only one doctor. In the latter case, the nurse becomes the doctor's assistant; the corpsman, who may or may not be an O.R. technician, takes over the duties of a scrub nurse. Where, may I ask, would we be if surgery had been eliminated from the curriculum in the schools we graduated from?

I'm not saying that well-trained non-professional technicians cannot do an excellent job. We have many

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corpsmen who do very well indeed, but here is an example of why student nurses do need surgical assignment as advocated by Miss Marie Charlier in her article, "Is O.R. Experience Necessary?".

SARA SQUIER, LT. NC USNR
BROOKLYN, N.Y.

Case for O.R.

Dear Editor:

In reference to the article, "Is O.R. Experience Necessary?" by Marie H. G. Charlier [Jan., 1954], may I add my cheers for those who think surgical assignment necessary? Thanks to my Alma Mater for my "two months."

Where is there a better place to learn aseptic technique? When is there a better time to learn the anatomy and physiology we are exposed to in theory during our first year as a student nurse, and examined on during state boards at the end of our third year? Surgery taught me more than any anatomy text book—and the knowledge is a must with all the insurance forms that are present now in a doctor's office.

What type of background would the aides and operative technicians have? Who has more need for a general nursing classroom background than a surgical nurse even though she *only* "sets up" and "holds retractors" and "counts sponges" and "threads sutures" and "is ready for any request at any time?"

And also, might it not be a good idea for the surgeons to answer a few questions and practice a little

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extra tolerance sometimes even though "under strain" – to help a nurse develop skills that will aid another patient later on. Why not ask the students if they want surgical training, or the surgeons if they want O.R. aides and technicians?

May we have some more on this subject–I just can't see how educators could consider eliminating O.R. experience.

R.N., KEENE, N.H.

Educator's Viewpoint

Dear Editor:

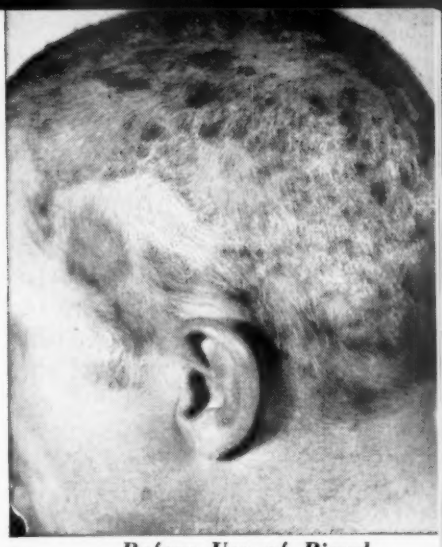
After reading the article "Is O.R. Experience Necessary?" I am prompted to present considerations which are important to this question in order to arrive at an objective answer to it. Some basic concepts need to be reviewed in the light of the nursing curriculum and the needs of the nursing student as well as the patient.

The main purpose of any basic school of nursing, whether it is a hospital or collegiate school, is to prepare the student for nursing. All those responsible for curriculum planning must answer the question: "What is the contribution of the operating room experience to the preparation of the student?"

The O.R. is only one of several departments of a hospital that offers a unique type of service to the patient. The relationship of this special service to nursing care is primarily one of the effect of the service upon the patient.

For too long a time the emphasis

PSORIASIS in children responds to RIASOL



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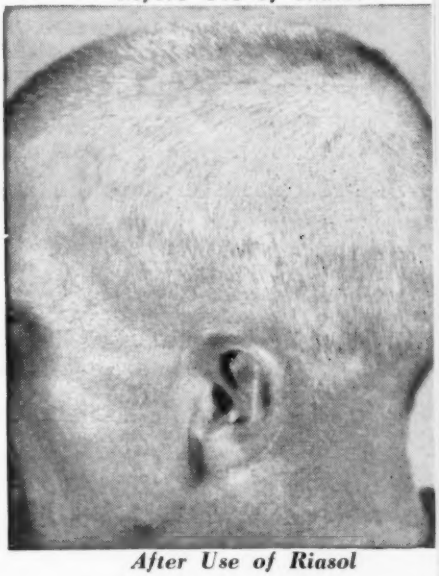

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"Psoriasis is a common affection in children from the age of five or six years onwards," write the pediatrists, Hugh Thursfield and Donald Paterson, in their textbook *Diseases of Children*. "In all cases of psoriasis in children it is possible to remove the eruption by local measures."

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in student experience in this service has been largely on the technical phase of the operation, a mechanical treatment of a disease or abnormal condition of the patient. Development of special skills for use in assistance to the surgeon has often been the main objective. All of the many ways and means available to the operating room nurse which provide for the safety of the patient have received less consideration.

Patients' reactions to surgical procedures are not immediately evident in the O.R., although these are important factors for the student in learning to plan patient care. And eight weeks' student experience, especially as a "second nurse," is totally insufficient to prepare anyone to assume the role of the graduate staff nurse in surgery. The newly graduated nurse so employed needs further planned training and guided learning experiences to function adequately and assume responsibility for this specialized service which must provide for the safety of the patient and maximum assistance for the surgeon.

Some reasons for an affirmative answer to the question which she poses in the title are given by the author. For the most part it would seem that these are valid reasons for a negative answer because:

1. Discovery of talent for operating room nursing, which as a small area of the larger field of surgical nursing, is outside the purpose of any school of nursing.

2. Though understanding of "the

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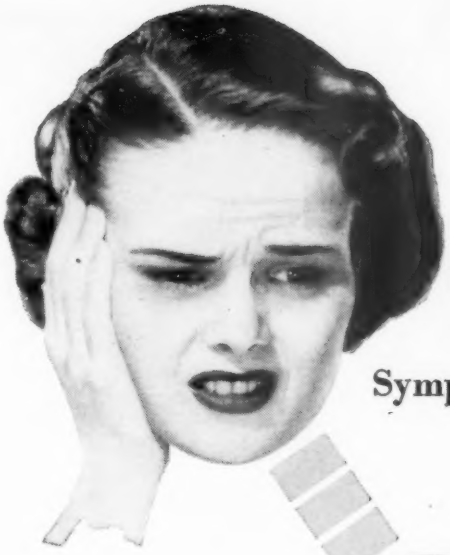
why of special care" of the surgical patient is important for the student to have, student operating room experience will not provide it unless, with proper instruction, it can be integrated with pre-operative and postoperative care and treatment of each patient.

3. Principles of surgical asepsis have to do with those procedures employed in the creation and maintenance of a sterile field whether it is an operative set-up, a tray for lumbar puncture, or dressing of a wound. No matter in what department of the hospital a need for these procedures may arise, the principles remain the same.

4. The "lessons in applied anatomy and physiology" the student receives during this experience are not frequent, rarely planned, usually incidental, and the same lessons are not available for all students in the class. Is it fair to a patient on an operating table, receiving increasing amounts of anesthetic drug, to be the subject of a lesson in anatomy? Minimal trauma to the patient is a major consideration of surgeons. Anatomical relationships and structures are best observed in the autopsy room.

The quality as well as the quantity of student experience in the operating room needs serious and objective study in order to justify its contribution to the basic nursing curriculum.

FLORENCE R. HAWKES, R.N.
CLINICAL INSTRUCTOR IN
SURGICAL NURSING
ORANGE, N.J.



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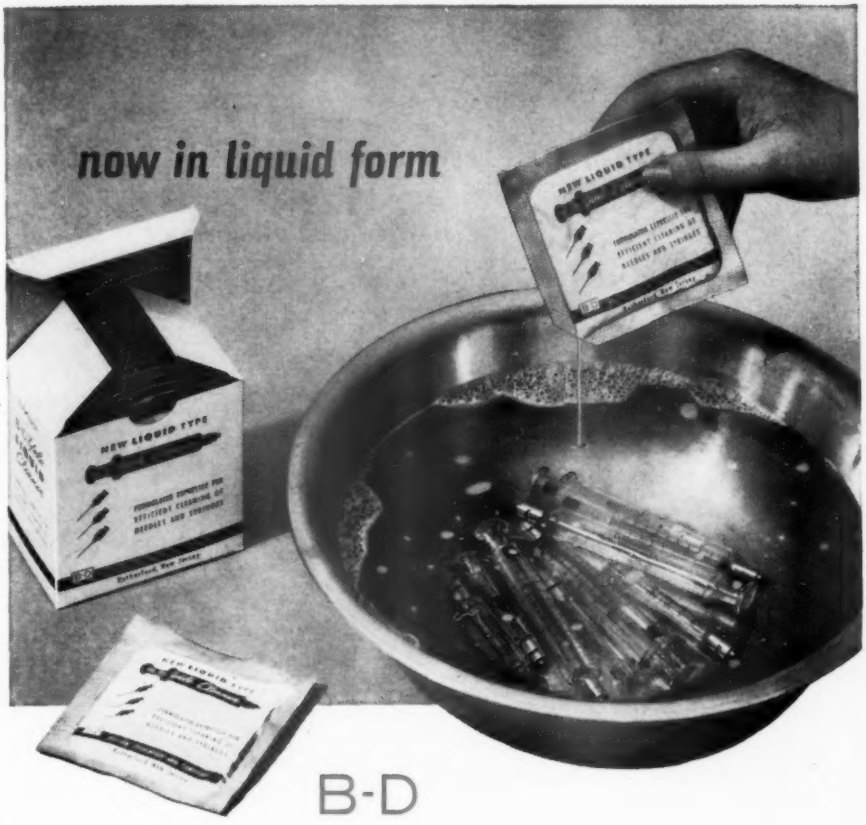

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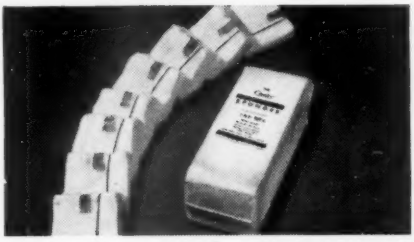

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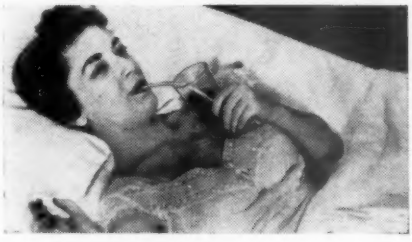

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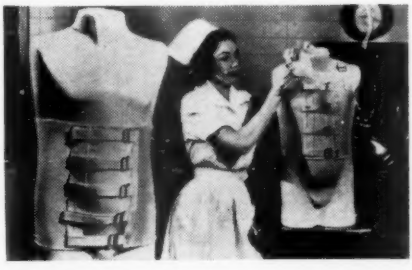

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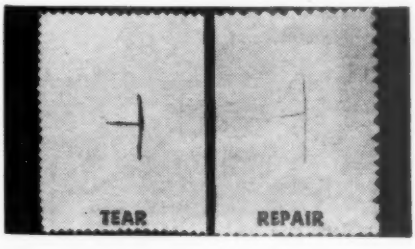

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CHLORINE	900 mg.	MANGANESE	0.4 mg.
COBALT	0.006 mg.	*PHOSPHORUS	940 mg.
*COPPER	0.7 mg.	POTASSIUM	1300 mg.
FLUORINE	0.5 mg.	SODIUM	560 mg.
*IODINE	0.7 mg.	ZINC	2.6 mg.
*IRON	12 mg.		

VITAMINS

*ASCORBIC ACID	37.0 mg.	PYRIDOXINE	0.6 mg.
BIOTIN	0.03 mg.	*RIBOFLAVIN	2.0 mg.
CHOLINE	200 mg.	*THIAMINE	1.2 mg.
FOLIC ACID	0.05 mg.	*VITAMIN A	3200 I.U.
*NIACIN	6.7 mg.	VITAMIN B_{12}	0.005 mg.
PANTOTHENIC ACID	3.0 mg.	*VITAMIN D	420 I.U.

*PROTEIN (biologically complete)	32 Gm.
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R548

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"Protection" in "Hazardous" Nursing

■ HE WAS, AS WE SAY in the vernacular, "on the soap box." I had phoned him, since he is associated with an organization interested in patient care, to ask a few pertinent questions concerning differential pay for what some nurses consider "hazardous" nursing.

While listening, and offering automatic rebuttals to his arguments that nurses were demanding unjustifiable additional fees for caring for certain kinds of illnesses, one phrase of his kept turning over in my mind: "nurses were trading in human suffering." What precipitated him to say that? It made me stop and view more objectively our present policy. Why *do* nurses charge extra fees for certain kinds of cases?

Why did a private duty nurse I know, after many months of "specialing" an organically ill patient in his home, immediately raise her rates when the attending physician commented that a mental depression was complicating the convalescence of her elderly patient.

Was it because the patient received a more skilled type of nursing care from that moment on? (It could have been, but not in this case—the private duty nurse had had not a day of psychiatric preparation.) Was it because the nurse, fearing psychiatric cases, thought an extra $2 a day would compensate her for any injury that might be inflicted upon her should the patient become violent? Or, was it because her state private duty section had authorized all its members to charge the extra fee for mental cases as soon as the physician had confirmed the diagnosis?

About a year ago I read in a state bulletin that a certain state private duty section had voted to limit the $2 differential fee then being paid for polio nursing to the actual isolation period. Before that action, such a fee was charged during the entire convalescent period and also whenever a patient with the diagnosis of poliomyeli-

tis was admitted to the hospital for any reason whatsoever.

Was the differential fee justifiable in the former policy? Were the attending nurses risking their health? Were the demands for specialized skills as great during convalescence and post-convalescence as during the acute stage? Or, did the nurses just get into the habit of charging the differential fee when they heard the diagnosis "polio"?

I've queried scores of staff and private duty nurses who care for alcoholics, and patients with tuberculosis, polio, and mental diseases as to why they think they should receive premium pay for these types of cases. The risk factor was given as a reason most frequently, and they sincerely believed that extra money would compensate them for their exposure to possible health hazards. The second point, a valid one where it actually applies, justified the extra fee on the basis of more skilled care of the patient because of the specialized preparation of the nurse.

In this day of shockingly understaffed sanitoria, there can be no minimizing the marked reluctance that so many nurses have to working in TB and mental hospitals. And those in charge of recruiting nurses for polio victims during epidemics can testify that the fear, real or exaggerated, of nurses is a professional problem of significant proportions.

And what financial provisions are made for the protection of the nurse disabled because she unknowingly comes in contact with an undiagnosed contagious disease or a patient temporarily psychotic?

Promises of financial protection cannot allay the underlying fears of some nurses of contracting a disease or being disabled by a mental patient, but would not more adequate protection be provided the nurse in form of broader insurance coverage through special group policies that have been either [*Continued on page* 75]

Photos from American Red Cross

■ MANY BLIND and partially blind persons are gaining new skills and a great deal of personal satisfaction through enrollment in the American Red Cross Home Nursing courses. At a number of places throughout the nation, they are being offered courses in home care of the sick and mother and baby care, receiving the same instruction as "seeing" people —and a bit more. Although the teaching may be adapted for best results, very few changes in actual content and method are required.

An hourglass has many uses, but when it is combined with a Braille thermometer it becomes an instrument effective in teaching the taking of temperature, pulse, and respirations to the blind. Through the use of a Braille thermometer, that has been imported from Switzerland, many students are prepared to take and record temperatures just as though they could see. If this new thermometer is not available, the blind are taught to clean ordinary clinical thermometers, shake them down, take temperatures, and then have the recording read by people who can see. Utmost utilization is also made of Braille slates and Red Cross Home Nursing Textbooks produced in Braille. With the help of the doctor or the druggist, students who have completed the course can also write Braille labels giving instruction for the use of medicines.

One of the earliest of these Red Cross classes was begun about ten

HOME NURSING for the BLIND

by Edith Wekselblatt*

At the Arkansas School for the Blind, students in home nursing are taught how to translate medicine labels into Braille.

years ago at the Virginia State School for the Deaf and the Blind at Staunton, Va., and classes have continued over the years. During World War II, when nurses were in short supply all over the country, students who had completed the course conducted at the school volunteered to serve on the wards of the Kings Daughters Hospital at Staunton. Since the inauguration of the course, blind and deaf students have served at the school infirmary, putting in long hours of duty during measles and influenza epidemics.

While the courses have been taught, in the main, at schools for the blind, they have also been conducted for adults in a number of communities, including such widely distant points as Queens, N. Y., Raleigh, N. C., Jersey City, N. J., Montana State College, Austin, Tex., and Oakland, Calif.

In a recent course for the blind offered by the Central Chapter of Queens, American Red Cross, students were recruited from the Industrial Division of the Lighthouse in Long Island City, N. Y. Registration was limited to eleven women and three men for the experiment, and classes were held in the students' cafeteria. Two nurse instructors were

*Miss Wekselblatt is director of Nursing Services of the Central Chapter of Queens, N.Y., American Red Cross.

present at all sessions to insure adequate supervision and to meet individual needs. The class met once a week for six weeks for two-hour sessions.

The students in this experimental group represented varied occupations. There were machine operators, packers, weavers, shipping clerks, a switchboard operator, and a supervisor of women workers. One student, accompanied by a seeing eye dog, was totally blind; the others were partially blind.

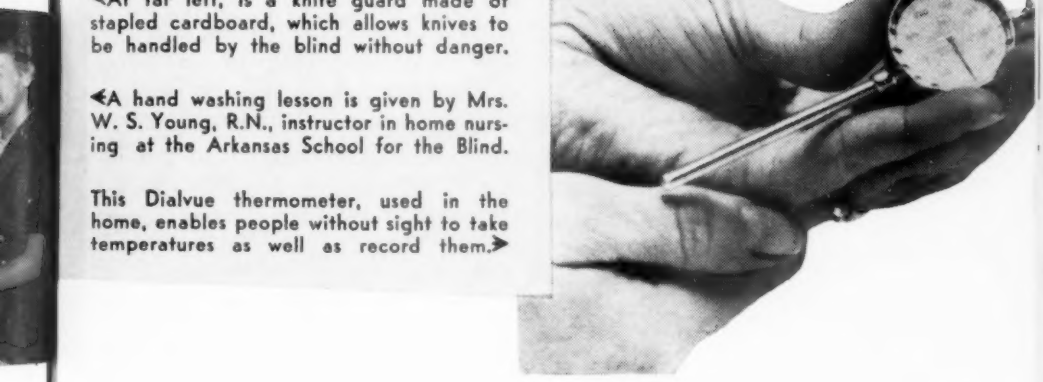
Before the course started, many of those interested in the new venture were apprehensive about teaching the blind to care for their sick at home. Was there really a need for this type of service and were the blind capable of caring for others?

The first question was answered at the first session when the students were asked why they registered for home nursing. One woman who was partially blind and hard of hearing had a young child at home. Another, a World War II veteran, with two children, wanted to assist his wife in case of illness. A third student was to be married to a co-worker in the near future and felt that this course was essential. The totally blind student was responsible for the care of an invalid mother. Actually, everyone present had a valid reason for taking the course.

In a sighted class, the instructor explains the principles underlying a procedure, followed by a demonstration and practice by the students. With this special group, the demonstration was not necessary, but additional guided practice was included.

Some of the skills learned were taking the temperature, pulse, and respirations, making an occupied bed, recognizing signs and symptoms of illness, washing hands properly, bathing an ill patient, giving simple treatments, preparing the diet, and administering medications as ordered by the doctor. Students also improvised such nursing aids as newspaper bags, paper slippers, and cardboard backrests.

Familiarity with the classroom was



≪At far left, is a knife guard made of stapled cardboard, which allows knives to be handled by the blind without danger.

≪A hand washing lesson is given by Mrs. W. S. Young, R.N., instructor in home nursing at the Arkansas School for the Blind.

This Dialvue thermometer, used in the home, enables people without sight to take temperatures as well as record them.≫

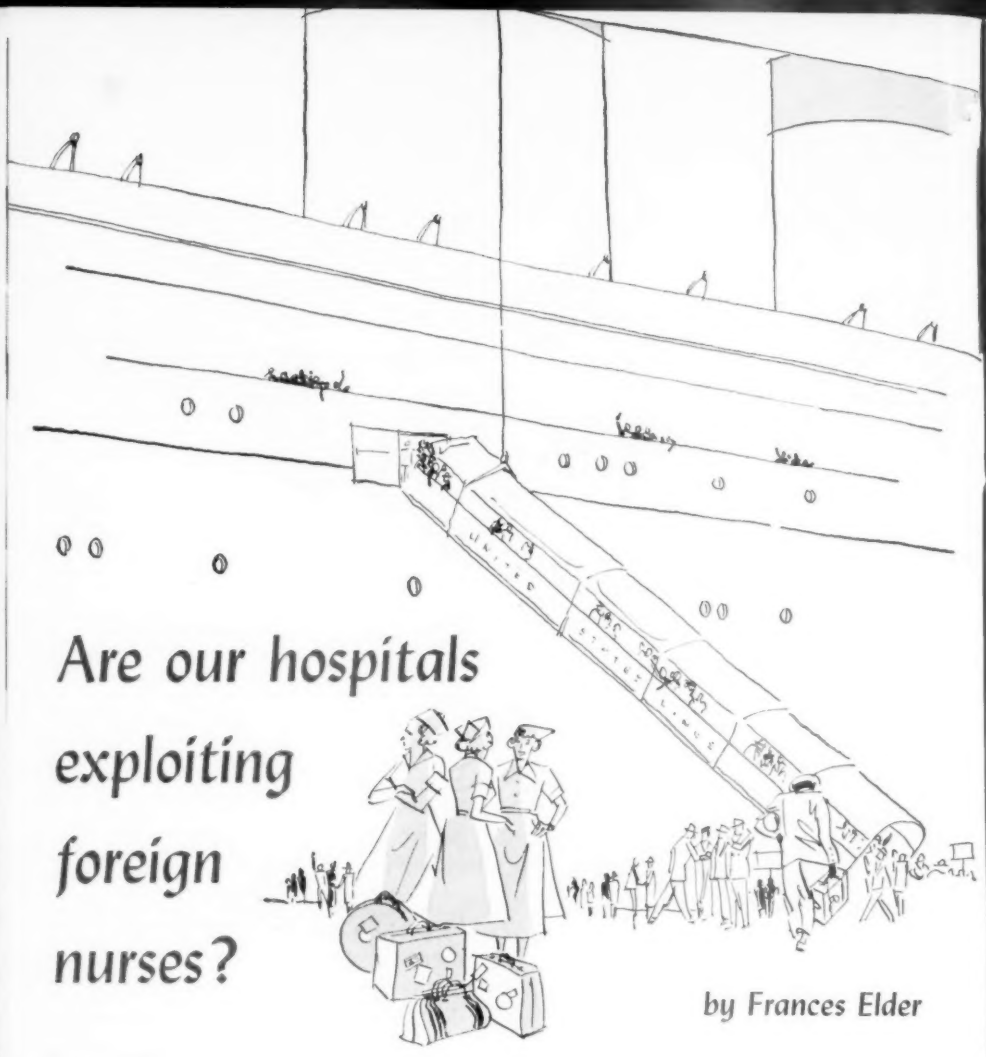
both an asset and a safety measure. It was interesting to the instructors to note the manner in which the students became acquainted with the pitcher, basin, and waste pail before proceeding to the practice of handwashing. When the group was completely adjusted to the situation, not one drop of water was spilled on either the table or the floor during the practice period.

The instructors of the course spoke slowly and clearly, and were quick to give encouragement and praise. The students learned slowly, but at the end of the course were adept and efficient as compared to sighted students who learn quickly because of visual aids, but who tend to be less meticulous.

The problem of how this group could identify the medicines in their cabinets led to a spirited discussion. One student read and wrote Braille and therefore would have no problem in writing a Braille label. However, since the others were unfamiliar with Braille, various improvisations were suggested. In the case of poisons, an inverted thumb tack was placed on the bottle as a warning. Other means of identification for medicines were a marble, a closed safety pin, or any other small elevated article pasted on the bottle.

Through a donation from the Lions Club of Forest Hills, a Braille thermometer was obtained for taking temperatures, and since most of the group did not own watches, hourglasses were used as substitutes. The thermometer was purchased from the Foundation for the Blind at the cost of $13.

The thermometer, consisting of a thermocouple device in the stem, is extremely sensitive and accurate. A dial on which the temperature is recorded is easily visible for those with some sight. On the rim of the dial are added the Braille elevated markings. A [*Continued on page* 86]



Are our hospitals exploiting foreign nurses?

by Frances Elder

■ OUR SHORES ARE fast becoming a mecca for nurses from other lands. Some nurses who come to our ports intend to remain, but many are due to return to their native land after a temporary stay in this country.

What brings this latter group of nurses to the U.S.? Probably, a variety of reasons. They may want to visit relatives living in America; they may be seeking knowledge of new nursing techniques; they may have the international disease of wanderlust; or they may be influenced by a combination of these factors and many others.

It's safe to say, though, that high on the list of our nurse visitors' objectives is a desire to gain meaningful experience—experience that will widen their own nursing horizons as well as those of their nurse compa-

triots when they return to their own countries.

That this travel objective has been given sympathetic attention in recent years is shown by the open-door policy of organized nursing as well as that of government and private agencies. More and more, we are coming to realize that free exchange of ideas among the peoples of the world promotes better understanding. Theoretically, at least, nurses from other countries who have lived, worked, and studied in the U. S. are more apt to be ambassadors of good will in their own countries.

This concept of furthering international understanding is embodied in the U.S. Information and Educational Exchange Act of 1948 which authorized the U.S. Department of State's Exchange Visitor Program. This program allows citizens of other countries, including nurses, to visit the U.S. for educational purposes on a non-immigrant basis. The exchange visitor visas of nurses who enter the U.S. in this manner are generally valid for six months or one year with a possibility of extension. Sponsors of the Exchange Visitor Program are those agencies which have been approved by the State Department and which have agreed to offer work experience and an educational program to visiting nurses.

Whether the worthwhile goal of the Information and Educational Exchange Act is attained, as far as nursing is concerned, will depend in large part on the treatment accorded foreign nurses in the U.S. While most nurses from other lands undoubtedly profit from their visit to the states, it cannot be denied that others do not gain as much as they should. Several institutions that have been officially designated as Exchange Visitor Program sponsors and have opened their doors to foreign nurses have failed to assume responsibilities that were rightfully theirs. Naturally, this has led to discord and disillusionment on the part of our nurse visitors.

One might question the purity of the motives of a hospital which wishes to be designated as a sponsor of the Exchange Visitor Program yet does not have the facilities to provide a proper educational program—one of the requisites of sponsorship. Is this hospital promoting nursing knowledge among foreign nurses or is it merely seeking an inexpensive way of augmenting a depleted nursing staff? Exchange visitors, it should be pointed out, are only paid a stipend designed to cover living expenses. This stipend is not considered remuneration for nursing services rendered.

In many instances, of course, the sponsoring agency wishes to add to its staff as well as offer a good educational program. In other cases, however, the greed for nurse manpower prevails. And unfortunately, it has been difficult for the State Department to check thoroughly on the facilities of the agency applying for sponsorship, or to see that rules were complied with after sponsorship was granted.

Fairly representative of the foreign

"Zeke & Dessie"

nurses who have entered institutions that could not carry the responsibility of sponsorship is a certain European nurse. We will call her Marie, though this is not her real name.

Marie is a young nurse, vivacious and attractive, with a good command of the English language—including slang. Ever since the end of World War II, she had wanted to come to the U. S. to study as well as to work in one of our large hospitals. One day while she was looking through a foreign newspaper she found an ad that seemed to offer what she wanted—a postgraduate course in her specialty. Marie wrote the director of nursing at the hospital which had been designated as a sponsor of the Exchange Visitor Program, obtained the necessary data for her visa, and in about a month arrived at the American hospital. (Advertising of the Exchange Visitor Program by hospitals is contrary to the regulations that have been set up by the State Department.)

After several weeks of routine staff duty, it was fairly obvious to Marie that no classes would be forthcoming. Requests for classes from other foreign nurses working in the same institution had already fallen on deaf ears. No teachers were available for special classes and the nurses could not leave the busy floors to attend the classes for students. Marie finally adjusted herself, good-humoredly, under the circumstances, to long periods of night duty and routine tasks that the regular staff nurses tended to avoid.

Fortunately, the situation at this particular hospital was finally brought

to light and the "program" was discontinued. Marie is now nursing at a small hospital in a suburban area and plans to enroll in a university nursing course this fall. She does not regret her trip to the U.S., but she does wish she had investigated a little bit more before entering a hospital here.

The sad fact is that the method that assures foreign nurses of good placement in U.S. hospitals and agencies is the one that is least used by nurses coming to the U.S. If Marie had planned her trip to the States with the help of her national nursing association and the American Nurses Association, which has been designated as a sponsoring agency, she would undoubtedly have had a more profitable experience. True, she would not have arrived in this country as quickly; on the other hand, she would not have wasted a goodly portion of valuable time. Insofar as possible, her placement would have been in an agency that would have provided a program to suit her individual needs.

The American Nurses Association, through its International Unit, participates in the International Exchange of Nurses Program set up by the International Council of Nurses. Other national nursing associations, that are ICN members, have developed similar programs.

There are several types of exchange privileges available to nurses who wish to go abroad. The nurses may enter a university for advanced study in public health nursing or nursing education; they may receive

clinical experience under supervision (under the Exchange Visitor Program); or they may request periods of observation in special fields of nursing. Employment for nurses on immigration visas may also be arranged for foreign nurses in this country or for American nurses traveling abroad.

Certain procedures followed by the national nursing associations participating in exchange programs are designed to promote the educational objectives of the ICN. Although these may be considered as so much red tape by nurses eager to start on their travels, they serve to guard against possible disappointment and frustration such as that experienced by Marie in her trip to the U.S. They also help to eliminate those nurses who would not gain from a trip to another country.

Nurses who come to the U.S. for study, observation, experience, or employment under ANA auspices must be graduate, registered or licensed professional nurses, as well as members of their national professional nurses association and recommended by it to the ANA. Prospective travelers are asked by the ANA to obtain the ICN application for exchange privileges from their nurses association and the appropriate visa from the nearest American Consul. They are also urged to plan ahead and have exchange forms on file at ANA Headquarters six months before expecting to travel. One of the basic requirements for these nurses is that they have a good working knowledge of the English language, including the ability to understand, speak, read, and write in English.

In this country, the ANA, as an Exchange Visitor Program sponsor, has placed a number of foreign nurses in hospitals and public health agencies which have definitely shown that they can provide an adequate educational program as well as specialized work experience. Officially, the ANA places only those nurses who apply through their national nursing associations, but it also helps those nurses whose sponsoring agencies have failed to supply the necessary type of experience and educational program.

Happily, it is becoming apparent that hospitals which do not keep their end of the bargain in the Exchange Visitor Program are being clamped down on. In New York State, for example, which has a mandatory licensure law, the Office of the State Board of Examiners of Nurses as a unit of the State Education Department has jurisdiction over all educational programs in nursing including those for graduate nurses under the Exchange Visitors Program. It is now exercising this jurisdiction to eliminate the wrong type of Exchange Visitor Program.

In order to secure work experience in New York State, a graduate nurse from a foreign land entering the state under visitors exchange must enroll in a course for graduate nurses which is approved by the State Education Department and which regularly requires a period of appropriate [*Continued on page* 68]

CANDID COMMENTS:

Why aren't nurses paid better?

■ While traveling on one of my favorite trains recently, the curiosity of the conductor finally got the best of him and he asked me who I was. Upon learning I was a nurse, he brightened. "My wife is a nurse too," said he, "Works in surgery. I've been trying to get her to give it up—the work's too hard. But I guess nursing gets in the blood; she feels she can't quit . . . Why don't you folks see to it that nurses get paid better? For what they put into their jobs they get less money than anyone I know." I couldn't answer his question in sharp black and white. It has too many ramifications, too many ties with lingering customs and traditions; there are too many complexities in today's form of nursing.

Janet M. Geister

One of the first reasons for nurses' inadequate salaries is the fact that the great majority of nurses are women—and women have not yet won their long battle for equal pay. It is taking our society a long time to learn to evaluate a worker's production according to its value rather than on the sex of the producer. For a century, American women have struggled to free themselves from legal and economic inequalities, and while the legal inequalities have been greatly reduced, prejudice and custom still play an important part in the employment and pay of women. In this, women themselves are partly to blame. They have tended—and still tend—to underrate the economic value of women's work. It happens in nursing as it happens elsewhere.

Another reason for the slow rise in nurses' salaries is the deeply rooted tradition that "nursing is a life of sacrifice." It is a field that calls for service "beyond the call of duty" whenever that need is present. But the sacrifice demanded in the past was wholly indiscriminate; nurses *must* sacrifice whether or not a need existed. It was simply out of character for nurses to ask anything for themselves. I well recall the stinging comments of certain medical societies when private duty rates went from six to seven dollars for a 12-hour day. And the shocked authorities when nurses asked for the 8-hour day. I remember grossly overworked nurses on split shifts and long hours, the while we were pleading for jobs for unemployed nurses. I remember, too, the nurses who were dropped when they finally broke down from needless as well as needful sacrifice, with nothing but memories in their bank accounts.

These things were due to the spirit of the times and not especially to a

coldly deliberate employment policy. The tradition is dying, slowly but surely. The split shift, the 12-hour day, the $40 a month check are gone. "The day has long since passed when hospital employes were asked to render charity as part of their wages," says Dr. Madison B. Brown,* highly respected hospital authority. Enlightened administrators and trustees realize that a service institution or agency is only as good as its personnel; the gadgets and fine tools are secondary. Our largest employers of nurses, the hospitals, are today highly organized businesses that provide health service at a price. Their primary equipment is united staffs with warm loyalties, pride, and a high morale—and these kinds of staffs aren't created on personnel policies that date back to the Civil War. Hospitals enjoy a monopoly in the nature of their services, but they face sharp outside competition in getting good personnel.

While the tradition is dying, it is still far from dead. There remain too many authorities who cling to their paternalistic control over nurses and who still rate equipment and buildings above quality of service. But the gains already made in personnel practices are way-signs of more to come. Reports in hospital publications on convention papers and discussion reflect a clear trend in this direction.

These facts, with others, point to what I believe to be the greatest single need in effecting equities in nurses' salaries—a program that educates all concerned in the economic as well as social values of professional nursing. Nurses, school teachers, librarians, social workers, and others in service professions cannot package their products neatly to show the man with the purse strings. Their products are entered in the lives of people, not on tally sheets. It is no coincidence that it is these groups who have the hardest time getting pay increases. The businessman trustee knows the value of his office staff's work and of that of the men in the plant. He can only guess at the economic as well as social values of the work done in the service fields. The prevailing pay rates indicate that he does not place a high valuation on them.

Organized nursing, seeking to enlighten community paymasters, has unfortunately based its claim to better pay for nurses on the rights and needs of the workers, rather than on the value of its product to the consumer. Do any of us buy our own commodities or services on that basis? Aren't we most interested, as we buy, in what our purchase means in *our* lives, or our neighbors'—rather than in the lives of those who produce these things? No thinking person can question the right of every worker to be paid according to the value of his work, and I have long felt that we would be in a stronger position if we stressed the value of our product rather than the rights—and needs—of the producer.

I quarreled bitterly with the publicity that went out a few years ago

*The Modern Hospital, July, 1953, p. 92.

showing the nurse as downtrodden—pitifully struggling to make both ends meet. In countless trips across the country and over countless years, I have yet to meet my first genuinely downtrodden nurse. There are many compensations besides money. I have, of course, met nurses who were terribly sorry for themselves, but happily they were not representative, and their number has been negligible.

Very few people outside of nurses have ever understood what professional nursing actually provides in skilled observations and protections and health promotion. This is especially true in regard to hospital nursing. In public health and industrial nursing, the educational programs have brought to others a clearer concept of these values. In the past, the nurse was "handmaiden" to the doctor, a pair of hands and feet to the hospital, someone to turn to in times of great trouble to the patient.

While these concepts have changed a good deal in the minds of progressive doctors and administrators, the problem of education in nursing's values has become infinitely more complex through the use in nursing of nonprofessional workers. Many conscientious administrators and well-trained practical nurses try vigorously to keep distinct the lines between skilled and "routine" tasks. But we also know that there are others who do not. Under cover of "economy" and "shortage of nurses" they get away [*Continued on page* 70]

Probie

"I couldn't tell them apart, otherwise."

What Is Pain?

by Morton J. Rodman

■ PAIN IS THE most prominent feature of most of the ailments that plague mankind and the symptom that most commonly prompts people to seek medical advice. As such, it serves the useful purpose of alerting the patient to the presence of disease and enabling the physician to diagnose and treat the pathology that underlies it.

Pain is one of our chief defenses against serious injury and death. Without it our lives would be happier, but they would very likely be shorter, too. The infected appendix, for example, might spew its poisons into the abdominal cavity before we were aware that anything was wrong and in need of correction.

Yet this protective mechanism may sometimes be destructive. Pain that robs the patient of rest, sleep, and appetite can undermine his physical strength and his morale, and long, continued pain may even set off a vicious cycle that can be extremely damaging to various vital organs of the body.

In addition to its clinical importance, the management of pain is of concern to doctors and nurses for humanitarian reasons. Nurses rarely become so conditioned to suffering that they fail to feel a surge of empathy at the sight of a haggard patient hunching himself against the onslaught of intractable pain.

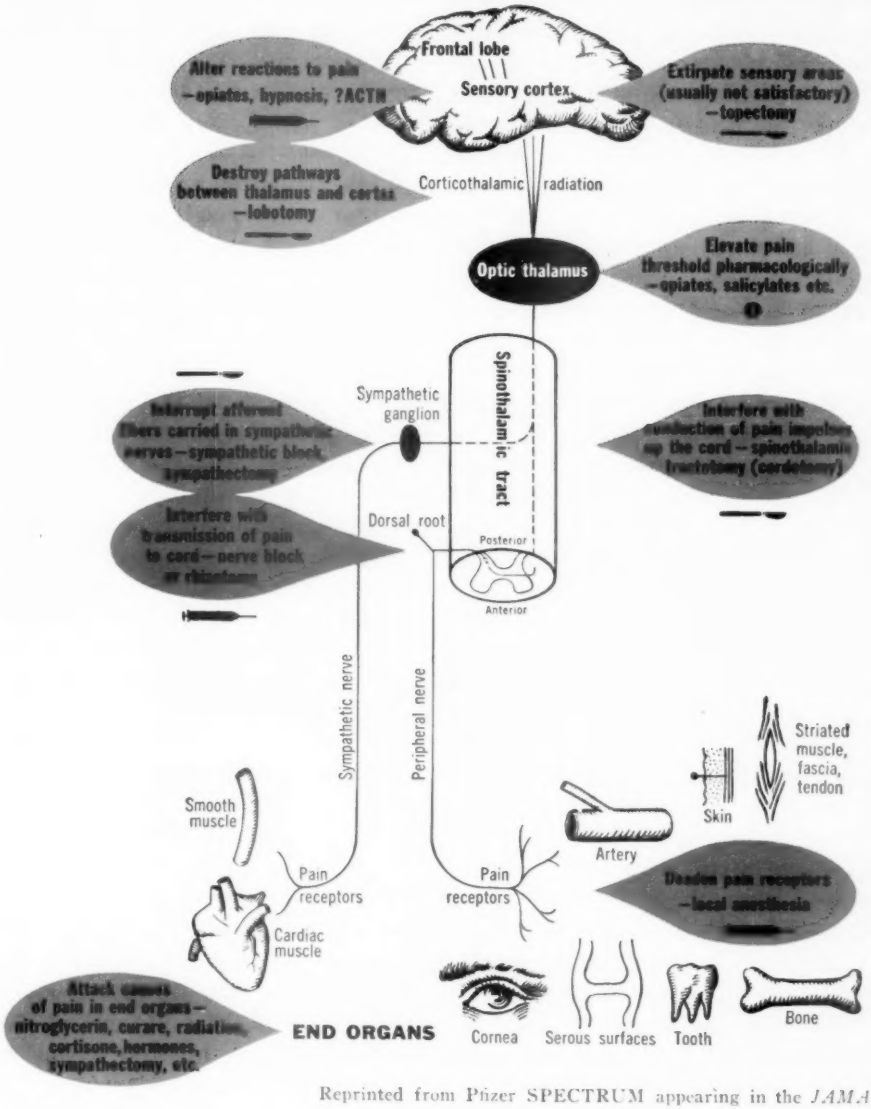
Recent research on pain and its problems has explained much that had previously puzzled medical science, and the doctors have been quick to fashion these findings into new weapons in the fight to control pain. Nurses, too, can put to good use this newer knowledge of the nature of pain, especially those facts that reveal the relationship between pain and emotion.

What, then, should the nurse know about pain and how to relieve it? Understanding the nature of pain requires consideration of two aspects of the subject: first, pain perception, which is a function of the anatomy and physiology of the nervous system, without much variation among most people; and, second, the reaction to pain, which varies widely from person to person and is dependent upon numerous psychological, environmental, as well as cultural factors.

Physiological investigations reveal that pain is a primary sensation, with its own specialized receptors, conducting pathways, and brain centers. To be felt by the individual, pain stimuli picked up at the specialized sensory nerve endings branching in the skin and deeper tissues must be carried by a complicated communications network to the seat of sensation in the brain. (See illustration on opposite page.)

The ability to perceive pain and to determine its intensity depends in large part on the intactness of this nervous hookup and on the number of impulses that reach the sensory cortex in the brain—the more im-

Pathways of Pain and Some Possible Roadblocks



Reprinted from Pfizer SPECTRUM appearing in the *JAMA*

This drawing shows the pain pathways from the periphery to the brain. The points in the pathways at which various drugs are thought to act and the sites at which neurological interference is done are shown in color.

pulses per unit of time, the more intense the pain.

But the way a person reacts to pain involves more than its mere perception, for when the message reaches the highest integrative levels of the brain, it is interpreted in the light of the person's past experience. It is the infinite complexity of the thought patterns set in motion here that accounts for the enormous variability in the way different people react to the same pain stimulus.

Despite these vast differences in the ability to tolerate pain, we now know that the point at which we first feel pain is pretty much the same for most of us. We know, too, that there is a limit to the amount of pain that can be felt and that once this point has been passed, the pain can get no worse and may actually lessen.

The concepts of pain "threshold" and pain "ceiling" and much more that we know about what pain is and why we hurt are the result of the pioneer studies of Hardy, Wolff, and Goodell at the Cornell Medical Center in New York. In their attempt to develop an objective, quantitatively accurate method of measuring pain, these three scientists came up with numerous new facts concerning the character of pain and laid to rest many a myth about it that had long been believed and passed along. To obtain their data, the group developed a gadget for inflicting measurable amounts of pain, the dolorimeter, and even established a measure, the "dol" (from the Latin, dolor, meaning pain).

Using this pain meter and the "dol scale," a pain intensity chart, the scientists can distinguish twenty-one degrees of pain, and have assigned values of aches and pains to various kinds. An ordinary headache, for example, may be worth only one or two units or "dols," while most migraines range between three and six dols, and the pain from a brain tumor may register up to eight dols. Injuries may call forth pain responses varying in severity from one or two dols for most cuts and skin abrasions to ten dols for some severe burns. Among the sharpest pains that humans suffer are those of childbirth, which hit the maximum of ten and a half dols.

Interesting as these results are, the method of study has not been free of criticism, nor have all the conclusions gone unchallenged. Other investigators claim that psychological factors in the reaction to pain are a source of error that prevent proper pain evaluation by means of any available instrument.

Dr. Henry K. Beecher and his group at the Anesthesia Laboratory of Harvard Medical School have carried on carefully controlled studies which indicate that there is a great difference between pain produced in the laboratory and that of the patient actually suffering natural pain. Dr. Beecher went into the combat zones during World War II and in the Korean conflict to study pain in soldiers recently wounded in battle. As a result of the questions he asked these soldiers and the answers he got from them and from postoperative patients in this country, Dr. Beecher has concluded that the use

of pain of experimental origin is artificial, because it doesn't take into sufficient account the emotional and psychological factors that can color the way we react to pain.

As every observant and thoughtful person has recognized, the severity of pain is often modified by the patient's reaction to it. People are often injured in accidents, or soldiers wounded in combat, without becoming aware of the pain until much later due to their powers of attention having been distracted in the excitement of the event. Under the stimulus of our instincts of self-preservation or the demands of our highest ideals of conduct, the brain may order us to ignore pain, as in the case of the hero who carries a child from a burning building without feeling the flames that sear his flesh. Likewise, martyrs and mystics in their ecstasies may manifest an amazing lack of sensitivity to the most severe torture their tormentors may inflict.

More common, perhaps, to the actual personal and clinical experience of the nurse, is the extreme variability with which women endure the pangs of childbirth or cancer patients react to the terminal stages of their illness. Not uncommon, too, is the neurotic, who in his morbid fear of cancer or of some imaginary condition, may suffer more pain than does a patient actually afflicted with the disease.

Yet people who respond to pain more intensely than most need not be neurotics or malingerers. Differences in the way people react to pain are the result of many complexly interacting factors that modify the way we interpret and evaluate the pain signals that reach our brain. Whether a person withstands pain with stoicism or dramatically exaggerates it depends on environmental and cultural influences, especially those he was subjected to in childhood.

Parental fears, attitudes, and afflictions often determine the way in which children react to pain throughout the rest of their lives. A person whose parents made much of every hurt will unconsciously mimic their

TV-Tailored Nurses

Drama is inherent in the medical and nursing professions. Novelists and dramatists have known this for years. So have radio script writers, especially the soap-opera variety. Very few, however, have portrayed the nursing profession as it really is—that is, attempted to show the public, through popular media, the type of service that the nurse is prepared to give. Recently, a much publicized television series, "Janet Dean, Registered Nurse," starring young TV actress, Ella Raines, has tried to represent the nursing profession as "an interesting, rewarding career that a girl can aim for and train for." From all reports, "Janet Dean" is drawing a large TV audience. But we're wondering how it scores with nurse TV viewers? Won't you tell us your reactions?

overreactions, while another from a less demonstrative family may not be bothered by pain of equal intensity. Indeed, even the kind of pain that hurts a person most may be the same kind that most bothered his parents. Joint twinges, for example, may attract special attention from a man whose father complained constantly of "rheumatism." On the other hand, sinus pain or intestinal spasm may cause the loudest complaint from members of a family conditioned to react emotionally to these parental ailments.

In the same way, a person may reflect the attitude toward pain of the natural or racial group in which he grew up. Anthropologists tell us that some primitive peoples perceive pain but refuse to recognize or respond to it. Among highly civilized peoples, too, there are differences in attitudes toward pain. Statistically speaking, for example, Scandinavians seem to withstand more pain than do people of Mediterranean origin. The differences, such as they are, are cultural rather than biological and, of course, indicate neither a "Nordic" monopoly on physical courage nor a southern stranglehold on sensitivity of feeling and the capacity to express what is felt.

Of course, factors more immediate than one's early background also have something to do with pain reaction. A person's job may toughen him emotionally to take in stride types of pain and discomfort that might draw loud protests from less hardened souls. Minor cuts and bruises as well as muscular aches and pains may be

Science Shorts

A wheel chair that can climb and descend curbs under the operation of a chair-ridden patient has been devised by engineers at New York University. Developed for the National Foundation for Infantile Paralysis, the curb-climber maneuvers curbs in less than a minute when the patient operates a mechanism of hand-powered cylinders and steel rods.

■

Infertility clinics now number 151 compared to 67 in 1949, states the Planned Parenthood Federation of America. A clinic survey covering the last 30 years revealed that 3,026 pregnancies occurred among 13,051 patients treated.

■

Heart patients are reassured on the safety of air travel in a recent news release of the American Heart Association. However, the report says that medical examinations are indicated before advising patients to fly, and stresses of flight, including reduced atmospheric pressure, vibration, noise, and fear of danger should be taken into account.

■

Mouth protectors for boys playing football and similar games are urged by three dental scientists in **The Journal of the American Dental Association.** ***It has been found that 52 per cent of the injuries of high school and college football players occur in the mouth area.***

■

A diet survey of the aged conducted in Westchester County, N.Y., and reported in *Geriatrics*, showed that older persons tended to neglect the food group containing yellow and leafy green vegetables, as well as dairy products and citrus fruits. It was also disclosed that vitamin supplements were taken by 44 per cent of the survey group and laxatives were taken routinely by 55 per cent.

A poisoning control program, that will aid physicians in treating child victims of poisoning from household substances and help prevent future poisoning cases, has been launched by the Illinois Chapter of the American Academy of Pediatrics. In the U.S., about 400 children under five years of age are known to die each year from accidental poisoning.

■

***Tea, taken in average amounts, need not be contra-indicated in the treatment of most gastro-intestinal conditions, is the conclusion suggested by data collected at Jefferson Hospital in Philadelphia and reported in the* JAMA.**

■

Radioactive gold shows promise in treating prostatic cancer, according to Drs. Robert O. Beadles and James M. Lewis, writing in the *Rocky Mountain Medical Journal*. In their opinion, the use of radioactive colloids may become standard treatment for prostatic tumors beyond the scope of radical prostatectomy, yet with no distant metastases.

■

Encourage children to be right-handed when they are about one year of age, says a medical consultant in the* JAMA. *The view is also expressed that retraining of left-handed persons in childhood and later in life should have no ill-effects when done kindly and patiently.

■

Statistics showing that VD is on the rise in about one-third of the 48 states, with much of the increase in the teenage group, have prompted the American Venereal Disease Association, the Association of State and Territorial Health Officers, and the American Social Hygiene Association to issue a detailed statement of facts, protesting reduction in federal support for VD control.

so routine to the farmer or laborer that he can ignore them and carry on without concern. Likewise, the ability of athletes to take bodily punishment that would send most of us to bed is due not so much to their physical condition as to their mental conditioning. This is especially true if the injuries occur during the excitement of a game when pain may be blocked out by the distracting influences that are competing for attention at the same time.

Not the least of the influences that determine how we react to pain is our immediate feeling state, that is, the extent to which we are contented and happy or fearful and tense. The sense of well being that comes from eating a good meal may, in itself, drive away a headache or relax painful muscle spasms; on the other hand, our reaction to pain is increased by anything that makes us uncomfortable—recall, for example, how cold, wet, and hunger tend to accentuate the misery of our aches and pains.

Even the more severe grades of pain, as in cancer and childbirth, are affected by the way we feel. In cancer, dread of the disease adds to the anguish of the sufferer by increasing his physical and mental tension. And as any nurse knows, who has worked in the labor room and assisted in deliveries, women who come to confinement with joyful anticipation and with knowledge of what to expect are less likely to suffer than those who are plagued by numerous fears and ignorance.

How, then, [*Continued on page* 76]

Drug Digest

CHLORPROMAZINE HYDROCHLORIDE (CNS Depressant)

PROPRIETARY NAME: Thorazine.

PHARMACOLOGY: Chlorpromazine is a new drug which appears to exert diverse and unique pharmacological effects on the central and autonomic systems and elsewhere in the body. Clinical studies now in progress indicate its possible usefulness in numerous branches of medicine including neuropsychiatry. It has recently been reported useful in management of the severe pain of advanced malignancy by its potentiating action on narcotics, that is, it makes narcotics more active physiologically. It has also been effective in controlling nausea and vomiting of these patients as well as the emesis associated with various other diseases, conditions, and drugs.

DOSAGE: Doses of 10 mg. to 25 mg. three to four times daily, orally or by deep intramuscular injection, are reported effective for control of nausea and vomiting, states of acute anxiety and agitation, and for potentiating the effects of narcotics. Smaller doses may be employed in less severe cases and for children.

UNTOWARD ACTIONS: Because of its many pharmacodynamic properties, the possibility of diverse undesirable effects exists. However, in the recommended doses, the side effects noted have been mainly mild or moderate drowsiness, and dryness of the mouth, as well as occasional postural hypotension, tachycardia, and nasal congestion.

LEVORPHAN TARTRATE N.N.R. (Analgesic)

PROPRIETARY NAME: Levo-Dromoran Tartrate.

PHARMACOLOGY: Levorphan tartrate is the levorotatory form of 3-hydroxy-N-methylmorphinan tartrate, a synthetic analgesic similar in action to morphine. Like the latter it is used to relieve severe pain due to spasm of smooth muscle of ureters, bile ducts, and blood vessels in such conditions as renal and biliary colic, peripheral vascular disease, gangrene, and myocardial infarction. It is also employed to control the intractable pain of inoperable cancer and other tumors, and has been used as pre-operative medication and for postoperative pain relief.

DOSAGE: An average adult dose of 2-3 mg. brings about analgesia equal in intensity to that produced by three or four times that amount of morphine and of longer duration. The dose should be adjusted, depending upon the severity of pain, the degree of tolerance, and the weight and age of the patient.

UNTOWARD ACTIONS: The danger of addiction is equal to that of morphine, and it is contra-indicated in the same circumstances as the latter. Side effects such as dizziness, nausea, and vomiting are more frequent in ambulatory patients. Levorphan tartrate is said to be less constipating than morphine.

LIDOCAINE HYDROCHLORIDE N.N.R. (Local Anesthetic)

PROPRIETARY NAME: Xylocaine.

PHARMACOLOGY: Lidocaine hydrochloride produces a more prompt, powerful, and extensive effect than procaine in equal concentration, when used for topical infiltration and block anesthesia in dentistry and general surgery. A single injection or application lasts for more than thirty minutes, but lidocaine may also be used for longer procedures by continuous drip administration, as, for example, in low caudal anesthesia.

DOSAGE: For infiltration anesthesia, solutions of 0.5 per cent strength (half that used in procaine anesthesia) provide a degree of anesthesia equal to that of procaine, with no greater toxicity. The amount of solution to be used varies with the extent of the area to be anesthetized—from 2 to 50 cc. in minor surgical procedures; up to 100 cc. for major ones. For block and topical anesthesia solutions of 1 or 2 per cent concentration may be employed, despite the increase in toxicity of lidocaine in higher concentration.

UNTOWARD ACTIONS: Muscular twitching, nausea and vomiting have occurred with the use of lidocaine. As with other local anesthetics, systemic absorption may cause a fall in blood pressure and central nervous system stimulation. Epinephrine hydrochloride added in concentration of 1:100,000 helps to delay systemic absorption. In prolonged operations, ephedrine counteracts vasodepression and barbiturates allay central nervous system excitement.

VINYL ETHER U.S.P. (General Anesthetic)

PROPRIETARY NAME: Vinethene.

PHARMACOLOGY: Vinyl ether is administered by inhalation, preferably by the open drop method, to produce rapid anesthesia of short duration. It is indicated mainly for minor surgical and dental procedures which do not require complete muscular relaxation. It has also been used as a basal anesthetic in pediatrics, due to its comparatively rapid and pleasant induction period. Vinyl ether is employed in obstetrics for various postpartum procedures, but it should not be used during labor because of the danger of respiratory depression in the fetus.

DOSAGE: Vinyl ether must be administered continuously to preclude too rapid recovery. At the same time close and constant observation of the rate, depth, and nature of respiration is required to prevent overdosage leading to anoxemia, cyanosis, et al.

UNTOWARD ACTIONS: Because overdosage may result in respiratory failure, an unobstructed airway and facilities for oxygen administration and artificial respiration must be available. The skin of the patient's face should be lubricated with a light film of petrolatum to prevent irritation. Increased mucus secretion, nausea, and vomiting may occur occasionally.

FASHION

designers' forecast

by Eleanor Lambert*

■ THIS YEAR the long-range shopper, who is primarily concerned with things to come in fashion, would do well to be familiar with the Byzantine period, the epochs of Louis XIV and of Madame Pompadour, the early 1930's and the 1870's—for echoes of these periods will resound far into 1955.

WATCH FOR . . . The boyish influence in junior fashion . . . The *Young Edwardian* designs—inspired by the group of bright young things in England whose light-hearted yet romantic outlook and nostalgic affectations in dress have charmed all of Europe in the past year—are prettily detailed with bright tartans and velvet braid, satin or grosgrain, although made in mannish fabrics with "gentlemanly" tailoring . . . The *"Chanel look,"* on the other hand, is soft, unself-conscious, immaculate looking, but with a dearth of detail. The unclinging middy with a straight-slim or flat-pleated skirt is considered the most popular version.

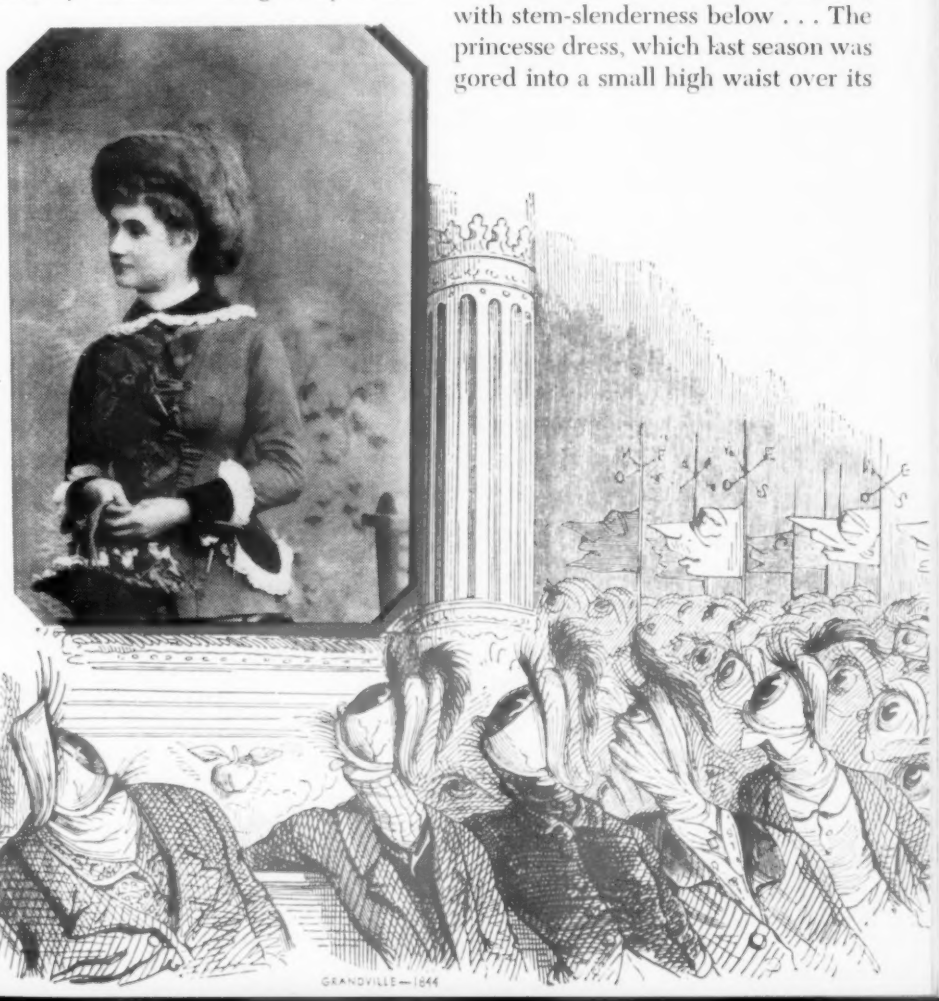
WATCH FOR . . . A more-of-everything trend in fashion . . . More fabric to give a new subtle expansion to the slim silhouette, yet showing more figure as designers introduce more clinging materials... Waistlines high, low, and normal with a slight tendency toward the low. Newly important are belted suits, while belted

*Of the Couture Group of the New York Dress Institute.

dresses remain in the minority . . . A trend toward casual, off-hand ease but plenty of studied every-stitch-in-place shapeliness. The soft *shirtwaist top* takes first place in every collection, on coats and suits as well as dresses . . . More costumes than individual coats, suits or dresses . . . More variables left to the wearer's choice: at least four accepted lengths for suit jackets . . . Hats with more brims than we have seen for a long time . . . More color than for years and years.

WATCH FOR . . . A decided *expansion of shoulders*—using every dress-making device except padding . . . Some are decidedly squared, others rounded and dropped far below the shoulder point . . . Soft, wide back folds on coats often extend beyond the shoulder line and give an illusion of width.

WATCH FOR . . . Continued bosom emphasis, but with a new focus *above* rather than below . . . With softer, deeper draping, the bosom looks flatter, less protruding . . . One version of the deepening, softening outline, the Flower Bud, plumps out in round fullness above a low waistline, with stem-slenderness below . . . The princesse dress, which last season was gored into a small high waist over its



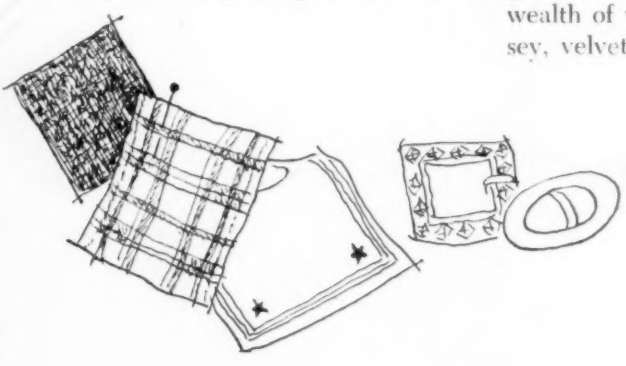
wide-flaring skirt, has two new moods for fall: the Louis XIV skirt with pronounced side-width achieved by little pannier pads set in under the lining, and the back-flaring Georgian skirt, gently or dramatically arranged with extra width and extra bulk at the back, while the front is only moderately full. This is balanced by the Georgian bodice, high-bosomed and with very full puff sleeves . . . A *Double Standard* in the silhouette is advocated by one designer — if it clings above the waist, it stands away from the figure below and vice versa . . . Separates designed to go their separate ways—on the campus, on the job, and ad infinitum.

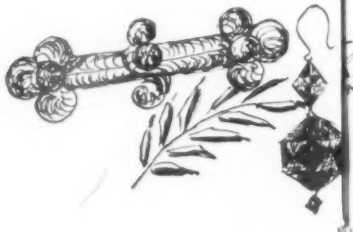
WATCH FOR . . . The long molded "dress form" torso on suits, coats, and dresses . . . Both full and slim skirts start at the thigh or have a smooth hip yoke to keep the line smoothly molded well below the waist . . . Definite deflation has set in, in the use of petticoats.

WATCH FOR . . . *Broken skirt lines* changing the sweep of both slim and full silhouettes . . . Emphasis on flounces, trumpet and moonflower flares, melon gores, fan pleats and low-placed flanges or pockets . . . The very full round skirt over multiple petticoats and the straight sheath have moved aside for more complicated, individualized skirt shapes.

WATCH FOR . . . Collars to tell an interesting fashion story . . . *Big collars* spread flat like a middy, drape shawlwise, loop or tie-like ascots (some at the back instead of the front) or swirl way up around the ears in exaggerated petal shapes, points or turtle necks . . . Collars often merge with the body of the garment, growing out of the back or shoulder or flaring out of the front seams . . . Many *double collars* of two fabrics or two colors.

WATCH FOR . . . *Fabric contrasts* as a major fashion keynote . . . Satin with tweed or men's wear wools, faille or flannel, silk chiffon and wool jersey . . . Contrast, too, in formal fabrics used casually and vice versa . . . There is a silken shimmer over everything . . . The nubby wool textures designers used to love are now fined down into polished, fuzzy, downy or flaky surfaces, with angora, cashmere, velour, chinchilla, and duvetyn important. A textured effect is often an illusion created by variegated color flecks in the weave . . . A wealth of winter prints on wool, jersey, velveteen or satin . . . Chiffon-

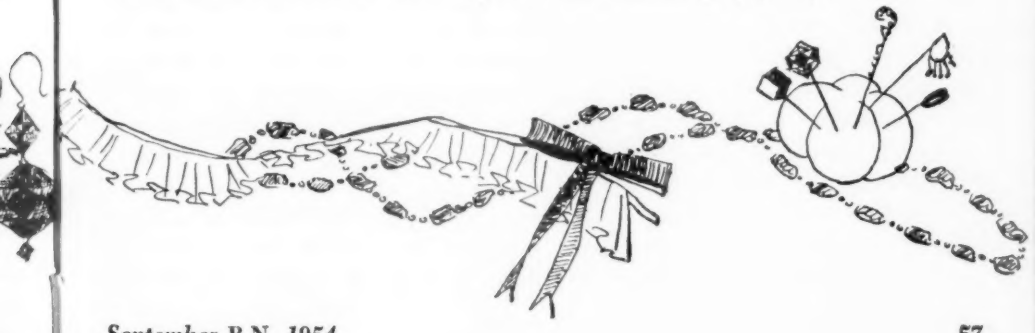


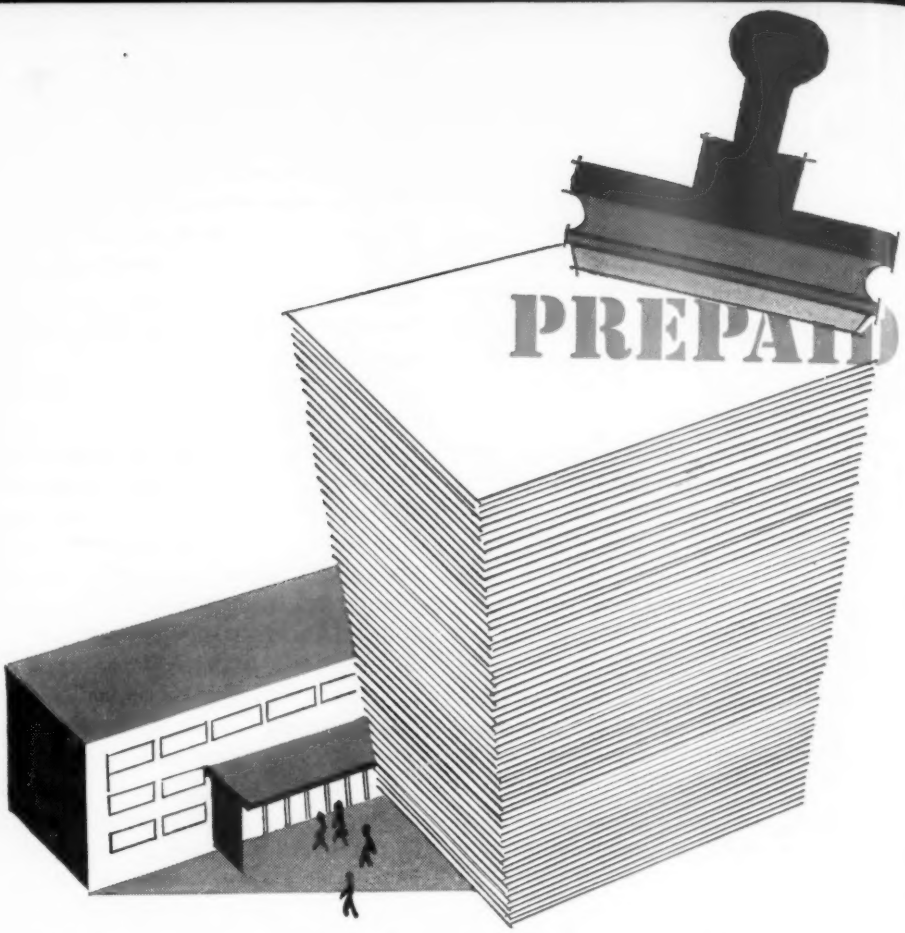


weight fabrics highly important, including tweed, wool jersey, broadcloth and mat jersey.

WATCH FOR . . . *A pageantry of color* that should beguile every woman away from black and neutrals . . . Even black is often not quite black (then it is called caviar), or is colorstruck by bright trimming or lining . . . In daytime, the mingled sparkle of bright colors in tweeds and brushed coatings . . . Tinted whites from ivory to an almost-green called Celadon light up evening fashions, while the beautiful clear blues, pinks and gem colorings in satin make radiant contrast . . . A number of fashions illustrate two equally colorful themes, the Alpine and the Aztec. Among the Aztec-colored costumes there are skirts in multi-color striped wool with a hand-loomed look—so beautiful they rate consideration from the girl in search of a good looking skirt . . . Bold, deep colors in Paisley patterns, plaids and striped woolens, strange new color combinations with an oriental or modernistic flavor as an intriguing new note . . . Equally important, the lovely bouquet colorings of the eighteenth century . . . *Brown* looms very big as a basic color this season with black sharing the honors.

WATCH FOR . . . A miscellany of new notes and little things that mean a lot . . . *The jumper* moving up to rival the blouse and skirt . . . *Longer slacks* because the new trend for full softness around the shoulders and the bloused look at the back of sweaters and shirts would make for wrong proportion with calf-cut pants. Slacks, however, have not gone back to the mannish shape, many fit the leg like an opera stocking and are made of beautiful and colorful fabrics . . . *Longer sweaters,* some so long they become dresses . . . Longer necklaces, some tucking into belts . . . Allover embroidered woolens for pretty and young casual clothes . . . Buckles as trimming . . . Marvelously rich and colorful linings in sober wool coats . . . Beaded decor under collars and cuffs . . . Fur collars that tie on, sailor collars that come off . . . Colored petticoat ruffles . . . Hand-crocheted edges for sweaters . . . Waist-length and hipline jackets that double as blouses . . . Jumpers that look as smart with jewelry as with sweaters . . . Quaint *tin-type touches*—ruching and velvet ribbons at throat and wrists, little folds of black lace on white linen collars, black soutache piping and occasional bits of jet prettify princesse dresses of brown flannel, black wool, and Oxford grey jersey.





Just three years ago in September, 1951, there appeared in* R.N. *an article by Ruth M. Stoneman on the Group Health Cooperative of Puget Sound in Seattle, Washington. In this article, Mrs. Stoneman, a public health nurse in the Cooperative, brings readers up-to-date on an expanding health program.

■ "INSURE WELL FAMILIES and keep them well to enjoy life without worry about expense of illness." That is the credo of the Group Health Cooperative of Puget Sound, which offers comprehensive medical service to more than 35,000 subscribers in the Seattle area. Of these Cooperative subscribers, 25,000 are members under a family plan, and the remainder receive industrial coverage.

As its name implies, Group Health Cooperative of Puget Sound resembles other types of cooperatives in that it is owned by the people it services. Medical matters are decided by the doctors, but administration, facilities, dues, services, etc., are controlled by the consumer-members.

Three years ago the Cooperative grossed $1,250,000. Today the volume of business is about $2,250,000,

nursing in a cooperative

on a strictly non-profit basis. Despite the growth in membership in the past three years, budget problems have plagued administration as evidenced by a recent increase in dues to take care of a sinking fund and provide for rising costs and higher standards of medical service, including the maintenance of a doctor-member ratio of 1:1,100, as well as a proper balance of nursing and other personnel.

Membership is open to families and to individuals under 60 years of age. The present cost per month for a family of five or more is $16 plus an initial family entrance fee of $25, and a $75 certificate entitling each family to one vote in deciding Group Health's policies and giving every member a share in the Cooperative.

The service offered by the Cooperative includes office calls, x-rays, and laboratory work, surgery, and treatment of fractures, physiotherapy treatments, and eye examinations. One hundred and eighty days of complete hospitalization for each condition is allowed, and a private room and special nurses are provided when ordered by the attending physician. Other benefits are drugs for one year for each condition (excluding vitamins, hormones, and insulin), emergency home calls, and complete child care for dependents. The total cost of maternity service is $80. Excluded from Group Health protection are such conditions as insanity, tuberculosis, venereal disease, alcoholism, and attempted suicide.

The Group Health facilities owned by the members comprise a three-story clinic building, a one-story clinic annex, a warehouse, and a 96-bed hospital which has recently received provisional accreditation by the Joint Commission of Accreditation of Hospitals. A branch clinic with facilities for ten doctors is about to be built in a heavily populated suburban area, and it is planned that several other branch clinics will be developed in the residential sections of Seattle.

One of the greatest hazards in this type of program seems to be the almost unlimited growth potential of prepaid medicine, and at present, until branch clinics can be financed and built, membership is being restricted to replacements of those who drop out of the plan. All applicants are carefully screened through a

by Ruth M. Stoneman

series of multiphasic examinations with appropriate referrals to physicians for further evaluation as needed. The interviewing techniques known to all experienced public health nurses are utilized in these examinations, and a public health nurse is in charge of this department working directly with the physicians, recording results, making referrals to physicians, and compiling statistics for management and the medical staff. In this way, the results of a complete set of basic examinations are entered on each patient's record for future use by his physician.

As a result of multiphasic examinations, early disease has been found, and patients are given an understanding of what preventive medicine really means. They come to realize that certain health problems such as obesity, defective hearing and vision, and other defects may lead to many emotional, physical, and social problems if not corrected.

It has become increasingly evident that the clinic care provided by the Group Health Cooperative is only as good as the tact, intelligence, and understanding of the nurses employed there. The nurse represents the busy physician to the members, for his care and treatment must be augmented and interpreted to the patient by his nurse. In private medical care, if a patient is dissatisfied with his treatment in a doctor's office, it is his prerogative not to return, but where he has paid a membership fee and monthly dues, he reports his complaints to a Member Relations department which investigates and attempts to correct all complaints. Many of these complaints stem from misunderstandings on both sides, rarely from deliberate acts on the part of either patient or medical team.

Members of this plan are further safeguarded by the practice of taking doctors on the staff for a six months' probation period. If the new doctor's practice of medicine or relations with other members of the staff do not appear to be harmonious with their ideals, his relationship with the group is quietly terminated. Unfortunately, ethics does not permit this to be explained to the members, and frequently they wonder why there is a certain turnover among the medical personnel. Recently, all other employes have been hired on the same six months' probationary period.

The thirty-eight physicians at the clinic each have an office nurse or, in some cases, two doctors share the services of one nurse. Nurses are in charge of the appointment desks since a knowledge of medical matters is essential to the proper disposition of patients' appointments. Nurses are also in charge of the dressing and injections rooms.

In addition to the clinic nursing personnel, nurses work in the 96-bed hospital next to the clinic. Here the usual nursing functions are performed with registered practical nurses as part of the team. Also included on the staff are nurse anesthetists working under an anesthesiologist and several nurses studying x-ray technique under the clinic's radiologist.

The clinic employs several female physiotherapists and pharmacists as well. It can readily be seen that this small medical unit offers many opportunities to the nurse who wishes to train in other fields.

The continuity of medical care from home to outpatient department to hospital and back home again appears to reduce morbidity and mortality rates in both medical and obstetrical fields and results in a slightly lessened rate in average hospital stay for some types of patients. Two public health nurses, working directly with the clinic physicians, make home calls of various kinds, and an agreement with the local visiting nurse agency makes possible referrals of selected calls to that group. From a ratio of one nurse call to one and a half physician calls in 1951, the nurses now make three calls to one made by the physician. The reception of this service by both physicians and patients points to a more widespread and economical method of treatment at home for many types of illness. Much care has been taken to keep the service within proper and generally accepted medical and ethical bounds, and in three years almost no complaint has been received.

The public health nurses are also engaged in another activity which has been well received by the members—a monthly series of expectant parents' discussion groups. Husbands accompany their wives to these evening meetings, see movies on childbirth, physiology, child care, etc., and meet the obstetricians. At the patients' request, these are not classes or lecture periods, but question and answer sessions that generally last at least two hours. The obstetricians report that women attending these meetings are much more relaxed during delivery.

Nurses seem to like nursing in the Group Health Cooperative. Employe turnover is low, comparatively speaking, and the main reason for resignations [*Continued on page* 81]

From the Spring 1954 issue of *Blue Print for Health*

News in Review

▶ *A GALA BROADWAY PARADE* replete with ticker tape greeted nurse heroine Mlle. Genevieve de Galard-Terraube on the first stop of her 19-day tour—New York City. "The Angel of Dienbienphu" who refused to leave the wounded after Dienbienphu fell to the Communists was invited by Congress to visit the U.S. through a resolution sponsored by Representative Frances P. Bolton. She has received numerous awards during her American travels. The first day in this country, at a reception held in her honor by Representative Bolton, the French nurse received citations from the American Nurses Association, the National League for Nursing, and Columbia University. The next day she flew to Washington where she was welcomed by President Eisenhower; other scheduled stops included Cleveland, Chicago, and San Francisco. Among the awards proposed for Mlle Genevieve de Galard-Terraube is the top Red Cross nursing citation, the Florence Nightingale award. She has been recommended for this by the League of Red Cross Societies and the American Red Cross.

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▶ *FUND RAISING CRACK-DOWN:* Charity agencies and professional fund-raisers and solicitors in New York State are now forbidden by law to use the names of persons or organizations without their written consent. The new law was enacted by the 1954 State Legislature as the result of disclosures of racketeering in fund-raising made last year in a legislative investigation.

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▶ *LABOR PROBLEMS:* To help meet the acute shortage of nurses, a day care center for pre-school children of R.N.'s has been opened at Montefiore Hospital, the Bronx, N.Y. There are accommodations for twenty-two children, Monday through Friday, and twelve more can be cared for over weekends. R.N. mothers pay the center $2 a day . . . The day after the Worcester City Council, Worcester, Mass., raised city hospital nurses' pay from $52 to $60 a week—thirteen nurses applied for jobs . . . In an attempt to block proposed cuts in fees charged patients under a government sponsored low-cost hospitalization program, thirty doctors staged a sitdown strike in front of the Welfare Ministry in Tokyo . . . A 10-cent hourly raise was won by the day-shift of twenty-one nurses who went on strike in an effort

to gain a $2 daily pay raise at Twin City Hospital, Dennison, Ohio. The superintendent and her assistant were the only R.N.'s on duty to care for the hospital's thirty-six patients.

▶ *THREE ALUMNAE* of the Hackensack (N.J.) Hospital School of Nursing have received degrees in advanced fields this year. *Miss Marguerite Kakosh* of Rochelle Park and New York City was the only member of her profession to be awarded the Degree of Doctor of Education by Columbia University. She was the twenty-fifth nurse in the U.S. to be thus honored, according to the Nurses Alumnae Association of Hackensack Hospital. *Mrs. Maria Schroeder* of Hasbrouck Heights, N.J., received a B.S. degree from New York University after attending night classes in public health for seventeen years. Mrs. Schroeder was graduated from Hackensack Hospital in 1928 and has been school and borough health nurse in Bloomingdale, N.J., for the last twenty years. *Miss Grace Bastian*, class of '42, received an M.D. degree from Johns Hopkins University School of Medicine.

▶ *NEWSLINGS:* In commemoration of her forty-seven years in the nursing profession, *Miss Vera M. Morehead* was awarded a citation by the alumnae association of the St. Thomas School of Nursing. Miss Morehead served the city of Nashville, Tenn., during five of its greatest disasters—the typhoid epidemic of 1908, the great East Nashville fire in 1916, Nashville's (and the nation's) worst train wreck on July 9, 1918, the flu epidemic of 1918, and in December, 1927, although on private duty, she volunteered to aid the homeless when the Cumberland river flooded its banks . . . In Lebanon, Pa., *Mrs. David Evans, R.N.*, was chosen Nurse of the Year by the Junior Chamber of Commerce, and a plaque was presented to her at the Street Fair of the Good Samaritan Hospital where she is a head nurse. The presentation, made for the first time this year, will be an annual event hereafter . . . A campaign to [*continued on page* 64]

About People

▶ ***MRS. MARY BRECKINRIDGE***, **founder of the Frontier Nursing Service, Wendover, Ky., recently received the 1954 distinguished service award of the National Federation of Business and Professional Women's Clubs . . . The Ohio State Nurses Association dedicated its headquarters to *MRS. ELIZABETH P. AUGUST*, who retired July 1, after serving thirty-one years as general secretary of the association . . . Dr. C. W. Mayo of the Mayo Clinic bestowed a kiss and the Edith Graham Mayo cash award, given each year in memory of his mother, upon *MISS LENORA SIMPSON, R.N.*, of Sioux Falls, S.D., for "going out of her line of duty to be kind and considerate to her patients." . . . The South Dakota State Nurses Association has a new executive secretary, *MISS AGNES B. THOMPSON*, who was director of nurses at the Sioux Valley Hospital School of Nursing for the last eighteen years . . . *MISS MARCELLE BEVINS, R.N.*, of Boston, Mass. reportedly has donated her 90th pint of blood . . . New president of the Louisiana Industrial Nurses Association, *MRS. MARGUERITE S. AHERN, R.N.* of the Lane Cotton Mills, is the only woman ever to be elected to the New Orleans Chapter of the American Society of Safety Engineers. Of 5,000 members in the national society, only six are women.**

inform high school students throughout the nation of career opportunities for health workers has been undertaken by the National Health Council in cooperation with, and financed by, the Equitable Life Assurance Society of the United States. The program, called "Operation Health Career Horizons," provides for the distribution of literature and posters to teachers, vocational counselors, and students in 26,000 high schools . . . Resort-type food with wine, plenty of rest, and a physical checkup all at regular weekday rates with no overtime lab costs or any extra charges are included in a "weekend special" program at Mount Zion Hospital, San Francisco. The "weekend special" for tired businessmen and tired housewives was inaugurated several months ago to help the hospital keep up its paying population over the ordinarily slack weekends. A symptom is the only reservation necessary. San Francisco is one of the few cities with enough hospital beds to permit such hospitality . . . Nurses?

▶ DECORATED: *Capt. Thelma E. Hadlock, ANC,* of Mesa, Ariz., now stationed at Letterman Army Hospital, San Francisco, was awarded the Bronze Star Medal for outstanding service as operating room supervisor of the Forty-third Surgical Hospital in Korea. *Capt. Mary B. Curry, AFNC,* of Council Bluffs, Iowa, received a Bronze Star for efficient handling of the "enormous increase in work due to the war in Korea." Capt. Curry was admission, disposition, and medical records officer at the Far East Air Force Headquarters in Tokyo. The Bronze Star Medal was awarded to *First Lt. Virginia M. Farrell, ANC,* of Fairfield, Conn., for meritorious service with the Twenty-first Station Hospital in Korea. She is now an instructor in hospital procedures at the Brooke Army Medical Center, Fort Sam Houston, Tex.

▶ FORMER VA Superintendent of Nurses, Gwen H. Andrew, has retired from the VA Hospital, Wadsworth, Kan. With the Veterans Administration since 1924, Miss Andrew served as VA Assistant and Superintendent of Nurses from 1941 until 1946. She is a graduate of the Army School of Nursing, Walter Reed General Hospital, Washington, D. C.

▶ WHEN EMPEROR Haile Selassie visited Minnesota, the National Student Nurses Association presented a hand-lettered parchment certificate to him in memory of his daughter Princess Tsahai, a nurse, who died in 1942 while serving in the Ethiopian Ambulance Corps. She was a graduate of Queen Charlotte Hospital in London. The certificate provides for $100 in books through the nurses' program of CARE.

▶ NURSES' SYMPOSIUM: Advances in medicine, surgery, and legal aspects of Workmen's Compensation and disability insurance will be among the subjects discussed at a symposium for nurses in industry in Albany, N.Y., October 8 and 9. The sponsors are [*Continued on page* 82]

Hospital Nurses Speak Up!

The nurses *really* spoke up in an Eastern hospital,* when they were put to testing the use of water and soap-and-water, on newborns . . . as against lotions. The complaints came thick and fast!

SO MANY MORE CASES of rashes and dry skin developed . . . that after a month's trial "it was felt advisable to return to the use of a lotion. . . ." So said a report** in a recent A.M.A. Journal, that covered the whole skin care study.

THE LOTIONS TESTED were labeled "Lotion A" and "Lotion B." "Lotion B" turned out to be Mennen Baby Magic Skin Care. Here's what the report said:

". . . the particular non-drying effect of the one with a cholesterol-type base (Mennen Baby Magic) was demonstrated, and its routine use in the prevention and treatment of dermatoses in infants . . . suggested."

TRY IT ON *your* "charges." You too, will find Mennen Baby Magic extremely effective.

Like Baby Magic, Mennen Baby Powder and Baby Oil . . . are products of the Mennen Company . . . Baby Specialist since 1880

*Study conducted at The Hahnemann Medical College and Hospital of Philadelphia.

**Fischer, C. C.: Clinical Study of Skin Rashes during the Newborn Period, A.M.J. Dis. Child. 85: 688-693, 1953.

Your Patients

...especially sensitive to

A recent survey[1] indicates that over 12,000,000 people in the U.S.A. yearly seek professional relief from the distressing symptoms of athlete's foot. Especially sensitive are those who make their living on their feet – all day long – day after day. *These are your patients.* They come to you in greatly increased numbers during these hot summer months when the incidence of crippling athlete's foot is at peak levels.

to ATHLETE'S FOOT

OCTOFEN® — Preferred Treatment . . .

SAFE

SIMPLE

OCTOFEN enjoys ready acceptance from the afflicted patient who must stay on the job, on his feet, day in, day out. In most cases, no time is lost — no awkward wet dressings or messy salves needed — just generous and repeated applications of OCTOFEN LIQUID on the affected parts in the office and in the home until relieved. Furthermore, OCTOFEN is non-irritating, greaseless, non-staining, kind to the tender skin, quick drying. For adjuvant treatment and prophylaxis, OCTOFEN POWDER, silk smooth and soothing, may be dusted liberally on the feet, in the socks, for added protection. OCTOFEN POWDER helps keep the feet dry—a must in treatment; curbs foot odors too.

OCTOFEN — True Fungicidal Action

OCTOFEN LIQUID and **POWDER** both contain effective concentrations of 8-hydroxyquinoline, *a true fungicide — death to T. mentagrophytes, arch criminals in athlete's foot.* OCTOFEN LIQUID kills the crippling fungus in 2-minutes flat, in laboratory tests. Clinical studies[2] reveal that this product is effective in over 90% of all cases tried. The most stubborn condition may respond completely in as little as a two week period. Containing moisture-absorbent silica-gel as well as the active fungicide, OCTOFEN POWDER is sound supplementary therapy.

1. MODERN MEDICINE TOPICS, 10:7, 1949 • 2. EXP. MED. & SURG.: 7:37, 1949

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Foreign Nurses

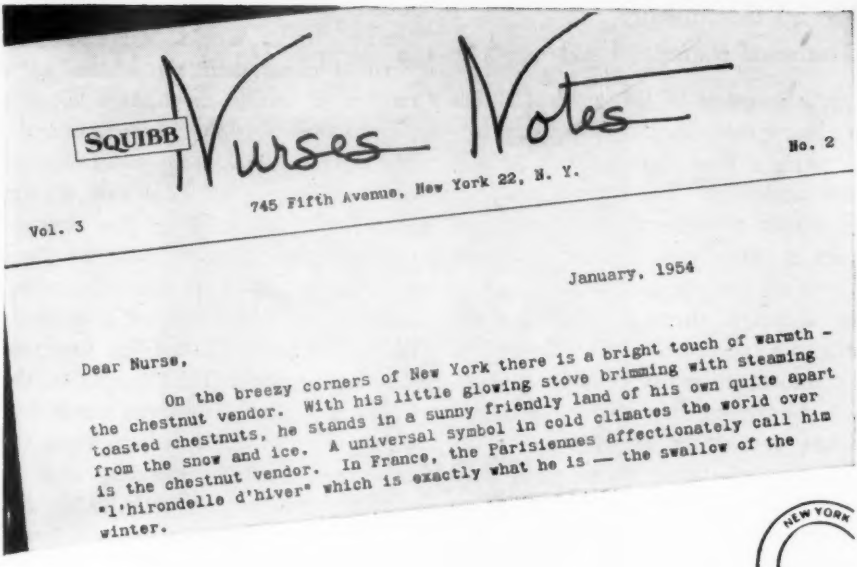
[*Continued from page* 42]

field practice in professional nursing. Only under these conditions could the nurse receive reimbursement, and this reimbursement would be in the nature of a stipend or scholarship for maintenance and other cost incident to the educational program. It would not be salary for services rendered to the agency.

In another state, which has permissive licensure, and where foreign nurses have been described as exploited, it is reported that the State Department has written the Board of Nursing for information on exchange visitor programs and has asked whether these have been approved by the Board. Letters have also gone from the State Department to certain hospitals in this state asking if their exchange programs have been approved by the Board. As a result of this official nudge, two hospitals have already asked to have their programs approved by the Board, even though the Board in this state does not control such programs.

It is interesting to note that there is a legitimate way in which hospitals can employ foreign nurses in states without a compulsory licensure law. They may file petitions (Form I 129) with the U.S. Attorney General requesting that aliens be granted immigration visas under a preferential quota. However, hospitals filing these petitions must show proof that they cannot obtain nurses in this country. This method of procurement should not be confused with the Exchange Visitor Program.

In contrast to the seamy aspects of the Exchange Visitors Program, which is undergoing strict, official scrutiny—and high time, too—there is a brighter side. It is to the credit of many institutions that they have complied with the necessary regulations governing the work experience of foreign nurses. The majority of our service organizations and American nurses realize that we have much to give these nurses who come to us with such high hopes. And they, in turn, realize that there is much that they can give us. In this chaotic world we live in, it is essential that we have a free exchange of professional ideas and ideals.



SQUIBB Nurses Notes

745 Fifth Avenue, New York 22, N. Y.

Vol. 3 No. 2

January, 1954

Dear Nurse,

On the breezy corners of New York there is a bright touch of warmth - the chestnut vendor. With his little glowing stove brimming with steaming toasted chestnuts, he stands in a sunny friendly land of his own quite apart from the snow and ice. A universal symbol in cold climates the world over is the chestnut vendor. In France, the Parisiennes affectionately call him "l'hirondelle d'hiver" which is exactly what he is — the swallow of the winter.

NEW YORK C N Y

SQUIBB Nurses Notes brings you the news

"Nurses Notes", the monthly newsletter published by Squibb, contains important, up-to-the-minute medical information of particular interest to nurses. Edited by Miss Joan Barlow, R.N., "Nurses Notes" is prepared as a professional service for members of the nursing profession. Special emphasis is placed on news in the nursing, medical, health and welfare fields. "Nurses Notes" is sent, free of charge, to members of the nursing profession.

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Name _____
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SQUIBB

Candid Comments

[*Continued from page* 45]

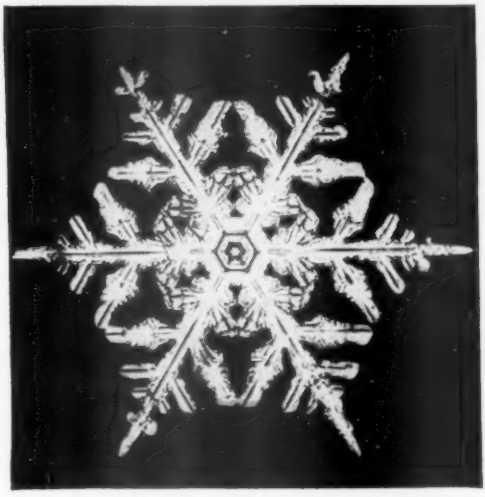
with a number of things that shock us almost into despair. I quote a letter from a fine young nurse in one such situation: "I've just completed six weeks of general duty, and my heart is literally in shreds. I'm back in private duty trying to heal part of the damage through giving good care to a patient. I saw so many sad conditions, so many needlessly neglected patients, that I spent sleepless nights reviewing the day's events and scenes." Other nurses have told me similar stories relating to poor nursing care.

A seriously ill coronary patient learned only by chance that the capped, white-uniformed "nurse" wearing a school pin, who had given her clumsy care, was a graduate of a correspondence school of nursing. The average patient has no way at present of knowing what values he is getting for his money—nor what values he should be getting. *We* know the distinctions between practicing the art of nursing that takes years to learn, and practicing the mechanics of nursing that can be learned in six weeks. *We* know the peril of considering "routines" all a matter of simple mechanics. Even a simple enema, given mechanically, can have a devastating psychological effect on a patient, says one doctor. Another* warns that the routine enema before surgery must be given with great care because the resistance of the bowel wall of a seriously ill patient may have been lowered. But if the patient, the taxpayer, the hospital trustee, and even some doctors, are unaware of distinctions between the art of nursing and its mechanics, how can we justify our plea for better salaries for professional nurses?

I believe most sincerely that a major reason for the slow progress of the ANA Economic Security Program is the lack of general understanding of what is good nursing. In the eyes of too many people, including some nurses, anyone efficiently performing the mechanics of nursing is "doing all right." Certainly they are doing all right within a pre-

*Nathan Shlim, M.D., *American Journal of Surgery*, May, 1954, p. 798.

Of exquisite delicacy...



A single snowflake highly magnified

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scribed scope, but if they are to be substituted for skilled care where skilled care is needed, we might as well close up shop. And in these days of high-powered medications and skilled treatments, what would happen to our patients if professional nursing care were not available?

The ANA Economic Security Program was voted into existence in September, 1946, by the House of Delegates—with adoption by state nurses associations on a voluntary basis. It calls for collective bargaining and signed contracts, with negotiations instituted by the state associations upon petition from any of its occupational groups—the sections. So far this is our *only* organized approach. It is impossible to gauge accurately the tangible results ensuing after eight years of intensive promotion—first, because though the states have varied considerably in their programs, there have been salary gains quite generally over the entire country. Second, the law of supply and demand has undoubtedly had an appreciable effect on these salary gains.

The program at present is, according to the ANA Committee on Employment Conditions, "on a plateau" —moving too slowly. On the Committee's recommendation, the 1954 House of Delegates voted to intensify action by demonstration and other means.

It seems to me that what is needed quite as much, if not more, is an objective evaluation of this method of achieving better pay and working conditions for nurses. While it is promoted in the interests of better care for patients, its center of interest is the *nurse and her needs.* It is only reasonable to urge that the ANA Economic Security Program be critically examined both for its efficacy and its philosophy.

In the interests of patient care, organized nursing cannot evade its duty to work for personnel practices that will attract and hold quality people. Action along a number of fronts is needed, but I am deeply convinced that above all we need a thoroughgoing, consistent, educational program that helps us, our allies, and our public to understand the social, economic, and community values of professional nursing.

"... and be sure she takes her VITAMINS!"

Gastrointestinal disorders interfere with vitamin intake and absorption through anorexia, nausea, vomiting, and hypermotility. Therapeutic diets may further limit intake. Adequate vitamin supplementation offers dependable protection against the development of avitaminoses.

MERCK & CO., INC., RAHWAY, N. J.—as a pioneer manufacturer of Vitamins—serves the Medical Profession through the Pharmaceutical Industry.

Editorial

[*Continued from page* 33]

sponsored by her state or even the national nurses association? Also, hospitals should have the legal as well as moral responsibility to insure their personnel either by Workmen's Compensation or by specific disability coverage when the types of patients they admit are recognized as being a threat to the health of the staff. Hospitals should also be held liable for the disability compensation of the unprepared personnel that they employ and who break technique out of ignorance.

It is my opinion that the differential-pay principle now in widespread practice not only is a short-sighted policy, lacks the protective features of insurance coverage, but worse, it penalizes the patient for his particular kind of illness, and, therefore, does leave nurses open to the charge of "trading in human suffering."

To comment on the second reason given for collecting extra compensation—statistically speaking, how many nurses have sufficient special preparation to be considered specialists in the particular fields of polio, tuberculosis, or psychiatric nursing?

What provision, to date, has organized nursing made to set up methods and machinery to examine and pass upon graduates' specialized skills? Have we, as have other professional organizations, established any specialty boards as yet? True, we may be heading in that direction with the formation of the Functions, Standards and Qualifications committees of the ANA and its constituent units, but we cannot say we have them now. And these are concerned with occupational not clinical nursing. Who then is in the position to decide which nurses are so qualified that they will have the privilege of charging extra fees for their specialized skills?

Another moot question: Are all the members of state private duty sections equally qualified professionally? And yet, are they not, according to the majority of the state minimum employment standards or personnel policies, encouraged to charge identical fees regardless of qualifications? And would it not also be a true statement that the private duty fee is based upon the *diagnosis* of the patient and not upon the skill of the nurse?

If specialized skills are needed for specific cases—and they certainly are in many instances—then it should be obvious that organized nursing is *not* meeting the needs of nurses and the community when it does not provide some form of examining board to pass on the qualifications of nurses desiring specialist's recognition.

Nurses who sincerely live by their pledge, "... I will dedicate myself to devoted service to human welfare," must see the lack of reasoning behind an organizational policy that offers questionable security to the nurse at the expense of the patient. We nurses need to do more looking-glass peering and see ourselves as our patients see us.

—Alice R. Clarke, R.N., Editor

What Is Pain?

[*Continued from page* 51]

is all this new scientific knowledge contributing to the clinical control of pain? Proper pain management makes use of surgery, drugs, and even psychotherapy, and may focus at any point in the pain pathway from the end organ in which it originates to the brain centers in which it is interpreted.

Obviously, the best way to relieve pain is to go directly to the source and do away with the painful condition by attacking it in various ways, depending upon the type of bodily structure in which it originates and the nature of the disease process. Thus surgical removal of a diseased gall bladder may solve that pain problem permanently and excision of a tumor may eliminate pain by relieving pressure on sensory nerve trunks.

Drugs, too, may act directly on an organ to stop pain at its source. Antispasmodics, such as belladonna derivatives, nitrites, curare, and mephenesin, that relax contracted muscles are among the most useful of these direct acting drugs. If the cause of the pain cannot be cured, a variety of drugs and surgical procedures that act by interrupting conduction of pain impulses may be tried by the physician.

Various neurosurgical procedures that cut the chain of pain conduction at different levels of the peripheral and central nervous systems have been introduced in recent years for the management of the intractable

pain of inoperable cancer and certain other conditions beyond the reach of the usual pain-relieving measures. These include sympathectomy, rhizotomy, chordotomy or tractotomy, transverse myelotomy, topectomy, and prefrontal lobotomy. (See illustration on page 47.)

Obviously, however, such neurosurgical and psychosurgical procedures are extreme measures that should be employed only after all other ways of preventing pain have been tried and found wanting. Anesthetics and analgesic drugs that act by temporarily cutting the conduction of nerve impulses at one point or another are usually found to be effective in combating most types of pain.

The general anesthetics, used mainly to facilitate surgery because of their ability to block pain sensation, have the disadvantage of depressing the whole central nervous system and causing a loss of consciousness. The local anesthetics, on the other hand, prevent pain without loss of consciousness and are used not only during surgery but also in conditions characterized by intractable pain. Administered in various ways that bring them into direct contact with pain receptors and sensory nerve fibers, such "nerve blocks" prevent transmission of pain impulses from the periphery to the spinal cord. Sometimes, however, prolonged paralysis may result from interference with motor impulses at the same time.

The true analgesics relieve pain without interfering with either con-

sciousness or motor activity. These drugs appear to act mainly by raising the threshold of various brain centers to pain stimuli so that fewer impulses register at such centers as the thalamus and the sensory cortex. For example, aspirin and other "coal tar" analgesics are thought to relieve pain originating in muscles and joints by lessening the ability of the thalamic cells to pick up such pain impulses and then relay them to the sensory cortex.

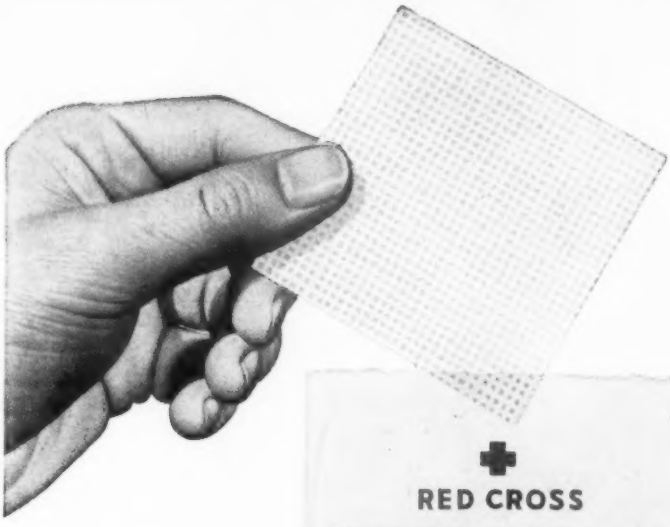
Analgesics of the latter type are not, however, very effective against pain of visceral origin. Relief of the sharp, piercing pain produced by spasm of smooth muscles usually requires the administration of morphine and related opium derivatives. These and the newer synthetic analgesics such as Methadon, Demerol, and Dromoran not only lessen pain perception but also modify the patient's reaction to pain. Unfortunately, the euphoria associated with this psychological action of the natural and synthetic opiates seems to be a factor in the development of addiction. In addition, the cells of the brain appear to adjust themselves rapidly to the presence of these narcotic drugs, so that larger and more frequent doses are required to produce pain relief.

Recent reports indicate that an interesting new drug, Chlorpromazine, intensifies and prolongs the action of narcotics. (Chlorpromazine, and three other drugs used to combat pain are described in *Drug Digest*, page 52.) The increased analgesia brought about by Chlorpromazine is believed to be due, in part, to its ability to change the patient's reaction to pain.

However, modifying the attitude toward pain is not limited to the action of new synthetic drugs. Hypnosis, which has been used from time immemorial by mystics and medicine men, has recently been revived by modern medicine.

But the successful use of suggestion requires no elaborate techniques. A sensitive and intelligent nurse by her attitude alone can often do a great deal to make her patient more relaxed and cheerful and better able to bear his pain. For we now know that the reassurance and emotional support of an understanding nurse may be more useful to a suffering patient than any other measure used in the management of pain.

Sterile until the moment of use!



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Prepaid Nursing

[*Continued from page* 61]

is usually found to be the imminent appearance of a new member of the nurse's family. Frequently, too, as their children approach school age, nurses return to work either on a full or part-time basis, and an effort has been made to help good nurses keep on nursing. Recruitment of physicians has been quite successful since a legal victory over the local county medical society several years ago established a precedent allowing membership in that organization to Cooperative physicians.

Without a doubt, prepaid medicine presents some problems. A good many of these appear to be associated with the proper usage of the outpatient department. A health educator, who was recently employed as head of the Member Relations department, is at present studying the educational problems inherent in this type of care. As in other situations where trail blazing was needed, some trial and error is almost impossible to avoid. However, the heartening thing is that although some members, used to the more personal care of their private physicians, terminate their memberships, a great many of these attempt to rejoin after reconsidering their sometimes hasty decision. All members are assured upon joining the Cooperative that imperfections exist, but that with their help as voting members in a democratic organization, constant effort will be made to improve medical care.

News

[*Continued from page* 64]

listed as the New York State Association of Industrial Nurses, the American Association of Industrial Nurses, Inc., the Union University School of Nursing, Albany, and the Liberty Mutual Insurance Companies. The registration fee is $5. Write Miss Ella G. Casey, R.N., McCrory Stores, 1107 Broadway, N.Y. 10, N.Y., for complete details.

▶ CAPITOL COPY: National Nurse Week has been set for the first full week in October . . . So far, according to the *Washington Report*, Senate-House conferees on the tax revision bill have agreed on the following points, among others: Fellowship stipends up to $3,600 a year will be income-tax exempt for a maximum of three years; the medical expense baseline is dropped to three per cent (at present, medical expenses must exceed five per cent of total income to qualify for tax exemption); hospital personnel and other employes who take meals, or lodging, or both, where they work may exclude the value of such meals and lodging from income—if they are furnished for the convenience of the employing institution or organization . . . The new vocational rehabilitation law—that has for its goal the rehabilitation of 200,000 persons a year—provides for financial aid to professional schools, hospitals, and other institutions which train personnel needed in physical rehabilitation, as well as stipends for the trainees . . . The House overrode its appropriations committee in approving $15.9 million to implement the expanded Hill-Burton construction program. (House Appropriations Committee had previously slashed all but $2 million in survey funds from the $35 million initially requested by the President.) . . . Senate Finance Committee finally decided to exclude physicians, dentists, veterinarians, and certain other self-employed professionals from Social Security coverage. The House is expected to concur . . . The President has signed H.R. 7125, a bill amending the Federal Food, Drug, and Cosmetics Act to protect consumers from poisonous spray residues on fruits and vegetables. The bill would prevent marketing of any pesticide until a tolerance is first established . . . Effective this month, dietary foods, represented to be of low salt or sodium content, will have to bear labels stating the sodium content per 100 mg. of food, as well as the amount of sodium contained in an average serving. To make it easier for patients to compute their intake of sodium, an "average serving" must be expressed in common terms; i.e., slices, wafers, teaspoonfuls, cupfuls, etc.

▶ NEW CODES for operating private hospitals, convalescent and nursing homes are being prepared or suggested in such widely separated states as New York, Illinois, Connecticut, and Florida. The Connecticut Private Hospital Association is drafting new regulations not be-

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Every week—see a dramatic, complete story about "Janet Dean, Registered Nurse," based on authentic case histories. Miss Raines portrays interestingly and effectively the career and services of a professional nurse. We sincerely believe that this television series will be an important asset in increasing the public's understanding and appreciation of the modern nurse and her problems.

See your local newspaper for time and station.

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Gentlemen: Please send me free the regular size, 29¢ bottle of Bromo-Seltzer.

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cause present standards are low but because it thinks they should be higher. In New York the situation is different. There Dr. James M. Rosen, president of the New York City Nursing Home Association, says as many as 150,000 elderly persons may be in unlicensed nursing homes.

▶ MEETINGS: A 35th annual health exhibit is to be held in connection with the 82nd annual meeting of the American Public Health Association in Memorial Auditorium, Buffalo, N. Y., October 11-15 . . . The Tri-State Conference of the New York, New Jersey, and Philadelphia branches of the American Association of Industrial Nurses will take place at the Hotel Warwick, 1701 Locust Street, Philadelphia, Pa., October 30-31 . . . Rehabilitation will be the theme of the 1954 convention of the National Society for Crippled Children and Adults, the Easter Seal Society. The convention is scheduled for November 3-5 at the Statler Hotel, Boston, Mass.

▶ NEW PROGRAMS: A new four-year program leading to a B.S. degree in nursing will begin this month at the University of Illinois. The work will be divided between the campuses in Urbana-Champaign and Chicago . . . A program of rural health nursing is included in the curriculum of the Department of Nursing of the University of Vermont this fall . . . The first unit of Yeshiva University—the Albert Einstein College of Medicine—will open in the

fall of 1955. A college of nursing will eventually be included in this $25,000,000 medical teaching center now under construction in New York, N. Y.

► REHABILITATION: The Institute of Physical Medicine and Rehabilitation at New York University-Bellevue Medical Center has announced another series of three-week seminars for nurses. Each seminar will be divided into three sections: I. Severe Disabilities and Their Rehabilitation; II. Skills and Methods of Functional Activities; III. Clinical experience. The dates of the seminars: October 25—November 12; January 10-28; April 4-22. Tuition: $60. To be eligible a nurse must have had a year's experience. For application and detailed information on the courses and hotel and living conditions, write Mrs. Edith Buchwald Lawton, Director of Rehabilitation Courses for Physical Therapists, The Institute of Physical Medicine and Rehabilitation, 400 East 34th Street, N. Y. 16, N. Y.

► FELLOWSHIPS in pediatric rehabilitation are now available for graduate professional nurses at the Children's Division of the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center. Applications for the fellowships may be made to Miss Mary Stewart, Educational Director of the Children's Division, The Institute of Physical Medicine and Rehabilitation, 400 East 34th Street, N. Y. 16, N. Y.

Home Nursing

[*Continued from page* 37]

button on top of the dial operates like the button on a stopwatch. When this button is pressed down, it records the temperature on the face of the dial and holds the button there until the button is pulled out again.

The students were taught to pull out the button and insert the stem of the thermometer in the mouth of the patient about one and one-half to two inches. Since this thermometer is heavier than a clinical thermometer, it is necessary for the patient or home nurse to hold it in place. After three minutes, just before removing the thermometer from the mouth, the button is pressed down and the temperature recorded on the dial.

The thermometer is held at the short end, in a horizontal position, and with the left hand starting at the first marking of 94 degrees Fahrenheit, the Braille markings are counted and read at the place where the second hand stops. It is only possible for the blind to read the temperature in degrees, not in tenths of degrees.

These thermometers are washed with soap and warm water, as compared with the clinical thermometer on which warm water is never used. They are sterilized in any sterilizing solution, such as alcohol or phenol, but not in bichloride of mercury.

The hourglass made a great hit with the partially blind students as they were able to distinguish between the sand-filled and the empty glass. They planned to use the hourglass for timing in their household tasks, such as in cooking and baking. In addition to the method of taking the temperature and pulse accurately, respirations were taught by having the students feel the bedclothes or the patient's chest.

All of the Red Cross nursing instructors who have participated in these courses agree that it is a stimulating and inspiring experience to teach blind students how to care for the ill at home. Classes such as that launched by the Central Chapter of Queens, and other time-tested courses have convinced the American Red Cross that home nursing for the blind is well worthwhile.

How Carnation protects the baby's formula from farm to bottle

Guards Your Recommendation Five Important Ways

1. Carnation store stocks are date coded, frequently inspected by Carnation salesmen to assure freshness, high quality.

2. Dairy cattle from Carnation Farms are shipped to supplier herds to improve Carnation milk supply.

3. Carnation supplier herds and equipment are inspected regularly by Carnation Field Service Men.

4. Research in the Carnation Laboratories guards the purity and nutritive values of Carnation Milk – develops improved processing methods.

5. Every drop of Carnation Milk is processed solely by Carnation, in Carnation's own plants, to Carnation's high standards.

The milk every doctor knows!

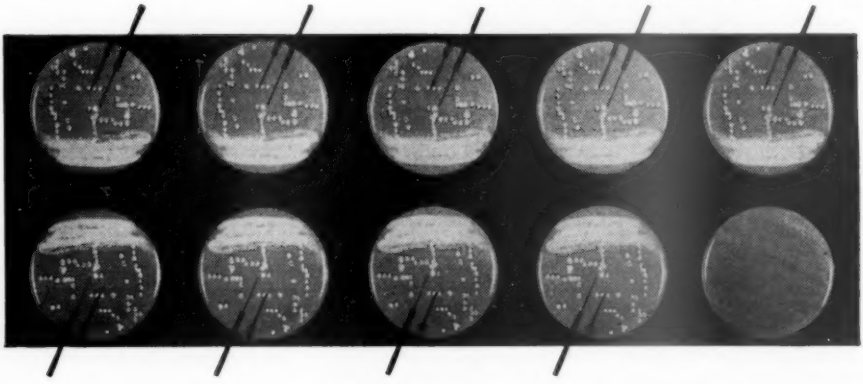
A NEW IDEA!

More and more physicians are suggesting the use of reconstituted Carnation Milk during the transition from bottle to cup, to avoid digestive upsets and encourage baby's ready acceptance of milk from the cup.

HERE'S WHY

9 of 10 women *with nonspecific vaginitis* respond favorably to MILIBIS®

VAGINAL SUPPOSITORIES



Whether of mixed bacterial, trichomonal or monilial origin, vaginal infections are often annoyingly persistent.

While mixed and nonspecific vaginitis occurs in women of all ages, it is most frequently associated with the menopausal patient who is experiencing a decrease in estrogenic secretions with consequent physiologic disturbances of the vaginal mucosa.

Milibis Vaginal Suppositories provide prompt, effective, well tolerated local antibacterial (nongonococcus) and antiprotozoal* therapy. Relatively insoluble and stable, Milibis is not readily absorbed or systemically disseminated; hence full potency is exerted at the site of infection and the hazard of sensitization or toxicity is minimized. Milibis Suppositories promote the restoration of normal vaginal flora.

Regimen: A Milibis suppository should be inserted in the vagina on alternate nights for a series of from five to ten administrations. Acid douches may be administered in conjunction with Milibis therapy. In especially refractory cases, the course of treatment may be expanded, or alternate regimen of 2 suppositories daily may be instituted for two weeks.

Supplied in boxes of 5, each suppository containing 0.25 Gm. Milibis in a gelatin-glycerin base.

WINTHROP **Winthrop-Stearns Inc.** New York 18, N. Y. Windsor, Ont.

Milibis, trademark reg. U. S. Pat. Off., brand of glycobiarsol

*Council on Pharmacy and Chemistry, American Medical Association: New and Nonofficial Remedies. Philadelphia, J. B. Lippincott Company, 1953, p. 158.

Positions Available

ADMINISTRATORS: (a) New vol. crippled children's convalescent hosp. to be opened in Nov., univ. city So. (b) Home for elderly people, resort city, Pac. Coast. (c) New hosp. 50 beds, now under construction, Florida. RN9-1 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ANESTHETIST: Starting salary $350 mo. Methodist Hospital, 6th St. and 7th Ave., Brooklyn, N.Y. SO8-6000, Ext. 142.

ANAESTHETISTS: A.A.N.A. member. 250 bed general hospital, salary open, automatic increases, laundry provided, 40 hr. week, no obstetrics, liberal vacation and personnel policies, Social Security. Sutter Hospital, Sacramento, Calif.

ANESTHETISTS: (a) Clinic staffed by 14 Board men, coll. town, near lge city, med. center, MW. $7200. (b) Chief. New hosp. 200 beds, resort town, N.C. $450 complete mtce. (c) Vol. gen'l hosp., 400 beds, dept. well-staffed, fairly lge. city, hour's ride NYC. $500. (d) Fairly lge gen'l hosp, Pac. Islands. (e) By oral surg., Calif. (f) Gen'l hosp. 300 beds, univ. city, near several resort towns, So. $500 plus %.Aver. $700-$800. RN9-2 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

CLINIC, INDUSTRIAL, OFFICE: (a) Clinic, affil. new hosp. unit univ. group, W. (b) Industrial, qual. conduct health prog. Chicago offices, lge. co. $350. (c) Clinic, famed hotel, substantial sal. apartment, univ. city, opport. continuing studies. (d) Indust. Take charge nursing dept., insurance co., M.W. (e) Office nurse qual. take charge, well known Board specialist, univ. city. RN9-3 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

CLINICAL INSTRUCTOR: In Obstetrics. 332 bed hospital located in an attractive residential section. Student body of 160. Degree in Nursing Education and some teaching experience preferred. Salary range for 40 hr. week, $320-$430. Beginning salary commensurate with experience and preparation. Liberal personnel policies. Living accommodations available. Apply to Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

DIRECTOR OF NURSING & NURSING EDUCATION: Northeastern hospital of approximately 250 beds. Require Bachelor's Degree in Nursing, experience as a Director, and/or two to four years experience as an Assistant Director of Nursing at a hospital with an accredited school of nursing. Excellent credentials required. Salary open. Box No. MH-1 c/o R.N. Magazine, Rutherford, N. J.

DIRECTORS OF NURSE: (a) Vol. gen'l hosp. currently under construction, will open July 1955 with 250 beds increasing to 600. Attractive city, resort area, So. (b) Dean, school operated by college, Pac. Coast. (c) New gen'l hosp. 350 beds, affiliated group staffed by 25 American Board specialists, suburb. location, East. (d) New hosp. school competent organizer req. Middle East. (e) Small hosp. & school, coll. affil., coll. town, Pac NW (f) Ass't dir., lge gen'l hosp. Outside U.S. Altho tropical country, mild pleasant climate. (g) Nursing service, new TB hosp. Coll. town. MW. $5600-6800. (h) Nursing service, vol. gen'l hosp. 350 beds, attrac. city, E. $5000-8000. (i) Psy. hosp. univ. city, SW. $6000-$6600. RN9-4 Burneice Larson, Medical Bureau, Palmolive Bureau, Chicago, Ill.

EVENING & NIGHT SUPERVISOR: 220 bed general hospital. Liberal personnel policies, 40 hr. week. Salary open. Apply Director School of Nursing, Malden, Mass.

FACULTY POSTS: (a) Chairman, univ. nursing ed. well qual. faculty. Up to $9000. (b) Ed. dir., clinical instructors, med. surgery. 300 bed gen'l hosp. vic. NYC. (c) Ed. dir., instructors in ped. psy., OB. Students mainly Orientals. Lge. gen'l hosp. outside U.S. (d) Instructors in ob. med. surg., nursing arts. Collegiate school, resort & coll. town, Calif. (e) Ped. instructors. Brazil, India. Psy. instructor, Brazil, nursing arts, Jordan. (f) Nursing Arts, small school, Chgo. area. $400, mtce. (g) Instructors, public health, med. surg., univ. nursing dept. E. RN9-5 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

GENERAL DUTY NURSE: For small hospital. Good salary plus full maintenance. Apply White Pine Hospital, Ely, Nev.

GENERAL DUTY NURSES: For 76 bed general hospital in university town. Prevailing salaries paid. Full maintenance available. Redlands Community Hospital, Redlands, Calif.

GENERAL DUTY NURSES: For 140 bed accredited hospital. All shifts. Good salary plus meals. 40 hr. week. Living quarters available. Located in heart of New York City. Apply Director of Nurses, Medical Arts Center Hospital, 57 W. 57th St., New York, N. Y.

GENERAL DUTY NURSES: All shifts for three year old 50 bed hospital in residential suburb of Chicago. Near Great Lakes and Fort Sheridan if your husband is in the ser-

vice. Bonus for relief, night call and supervisory duty. Paid overtime, excellent personnel policies. Apply Director of Nurses, Highwood Hospital, Highwood, Ill.

GENERAL DUTY NURSES: For 120 bed hospital, southern Wyoming community of 12,000. Liberal personnel policies. 40 hr. week. Starting salary $237.50 with a charge of $22.50 for full maintenance. Surgical nurses, starting salary $247.50, additional $10 per mo. for evening and night duty, regular increases. Nurses' Home recently redecorated and refurnished. Write Director of Nurses, Memorial Hospital, Rock Springs, Wyo.

GENERAL DUTY NURSES: For beautiful crippled children's hospital located in heart of historic west. Salary starts at $205 per mo. with complete maintenance, 15 days vacation, 15 days sick leave, 5 day work week. Climate is warm and dry. Hospital has indoor and outdoor pools available to personnel. Contact director of nurses, Carrie Tingley Hospital for Crippled Children, Truth-or-Consequences, N.M.

GENERAL STAFF NURSES: This is a nice place to work in preferred department of 200 bed general hospital with liberal personnel policies including 40 hr. wk., choice of two schedules, retirement plan, paid hospitalization insurance premium, cumulative 30 day sick leave, pro-rated and progressive vacation, 6 holidays annually, meals at cost, rooms for $20 monthly in residence beautifully located directly on Detroit River and 30 minutes from Detroit. Beginning salary, evenings $304.47-$313.13; nights, $299.47-$308.13; days, $289.47-$298.13. For details write Director of Nursing, Wyandotte General Hospital, Wyandotte, Mich.

GENERAL STAFF NURSES: 250 bed general hospital and 72 bed maternity hospital. Starting salary $280, $5 per month tenure increase for each 6 months of service to a maximum of $310. Social Security, sick leave, prepaid medical and hospital care. $10 additional for afternoon and night shift, $10 additional for delivery room, $20 additional for surgery. Up to 3 weeks vacation at end of 4 years. 7 paid holidays, 8 hr. day, 40 hr. week. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GRADUATE NURSES: Two, who either have or are willing to obtain Colorado registry. Floor duty, rotating shifts, starting salary $250 per mo. 44 hr. wk., laundry furnished, under Social Security, 2 wks. pd. vacation per year. High in the new Uranium Country. Southwest Memorial Hospital, Cortez, Colo.

GRADUATE NURSES: Two, with institutional psychiatric experience for general and supervisory duties, eligible Nevada License. Address Superintendent, Nevada State Hospital, Reno, Nev.

HEAD NURSE: Delivery Room. 332 bed general hospital with School of Nursing. Degree and experience desired. 40 hr. wk., liberal personnel policies, living accommodations available, salary commensurate with qualifications.

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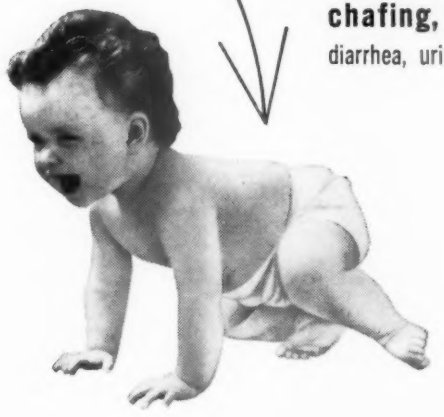
in **extensive dermatitis, diaper rash, severe intertrigo, chafing, irritation** (due to diarrhea, urine, soaked diapers, etc.)



DESITIN OINTMENT achieved "significant amelioration" or practically normal skin in 96¾% of infants and children suffering intense edema, excoriation, blistering, maceration, fissuring, etc. of contact dermatitis. This and other recent studies recommend Desitin Ointment as "safe, harmless, soothing, relatively antibacterial"..... protective, drying and healing.[2-4]

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1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgergy. 18:512, 1949.
4. Turell, R.: New York St. J. M. 50:2282, 1950.

Position available immediately. Apply Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

HIGH CALIBER REGISTERED NURSES: We need good nurses interested both in latest scientific therapy and old-fashioned warm care of patients with cancer and allied diseases. University affiliated inservice education plus access all N.Y.C. universities. Staff nurse salary $260-$300, evening bonus $50 monthly, night $40, 5 uniforms laundered weekly, paid Blue Cross, Social Security, 4 weeks vacation and other benefits. Minimum rotation. Housing agent helps you locate. Write Director of Nursing, Memorial Center, 444 East 68th St., New York 21, N. Y.

MALE NURSES: (a) Anes. Small gen'l hosp. lge city med. center. $8-9000. (b) Staff supervisors med. center. (c) Supt. priv. hosp., univ. city, Md. $5200, mtce. RN9-6 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

MEN NURSES, REGISTERED: Several positions open in all-male hospital. Starting salary $280. 3 weeks paid vacation after 1 year. Usual holidays. Morning and afternoon shifts. Differential for afternoon, evening. Address: Director of Nursing, Alexian Brothers' Hospital 18, Mo.

NURSE ANESTHETIST: For 120 bed general hospital. Present staff of two. Terms of employment open. Living-working conditions excellent. 45 miles NYC. Contact David H. Welsh, M.D., Dir. of Anes., Newton Memorial Hospital, Newton, N. J.

NURSE ANESTHETIST: General hospital, 700 beds. Starting salary $4300 per annum, maximum $4800 per annum, $100 yearly increments, vacation and sick time. Full maintenance provided. Contact A. G. Chmelnik, M.D., Medical Director, The Harrison S. Martland Medical Center, 116 Fairmount Ave., Newark, N. J.

NURSE ANESTHETISTS: Two. To increase our staff of nurse anesthetists. The hospital is 116 beds, new, modern and well equipped. Salary is based on a 5 day week and case basis is used for overtime. Address: Mrs. Carolyn Heisler, Administrator, North Shore Hospital, 9200 N.W. 11th Ave., Miami, Fla.

NURSE ANESTHETISTS: Two. Above average salary. Medical Anesthesiologist in charge. Inquire C. K. Shire, Administrator, Montana Deaconess Hospital, Great Falls, Mont. Call at hospital expense.

NURSE ANESTHETISTS: (2), to increase staff. Working conditions excellent. Apply Chief, Anesthesia Dept., Mercer Hospital, Trenton, N.J.

NURSE DEMONSTRATOR: Registered nurse with personality and ability to demonstrate new bandaging techniques in hospitals and first aid departments of industrial plants. Some travelling. Salary commensurate with ability. Must locate in Chicago. Write Box SMC-1 c/o R.N. Magazine, Rutherford, N. J.

NURSES: Nursing Arts Instructor, Clinical Instructor, Pediatric Instructor. 200 bed general hospital, 90 students. Degree in nursing education preferred. Salary commensurate with preparation and experience. Living accommodations available. Apply Director, School of Nursing, Malden, Mass.

NURSES: Have immediate openings for registered medical, surgical and obstetrical nurses for day, evening and night duty. Minimum starting wage $250 per mo. $15 per mo. differential for evening and night duty. 40 hr. wk., paid vacation, 6 legal holidays, sick leave and excellent working conditions, laundry furnished. Write, wire, call or apply in person to the Personnel Dept. Research Hospital, Kansas City, Mo.

NURSES: General hospital, 236 beds, new building, modern equipment. 30 miles from New York City. Liberal personnel policies. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N.J.

NURSES: General Duty, for 30 bed hospital 35 miles from New York. Excellent salary. Apply Administrator, Tuxedo Memorial Hospital, Tuxedo Park, N.Y.

NURSING ARTS INSTRUCTOR: Nationally accredited school, 75 students. B.S. Degree and teaching experience required. 40 hr. wk. and employee benefits. Apply Dean, Knapp College of Nursing, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

NURSING ARTS INSTRUCTOR: One assistant, temporarily accredited with N.N.A.S., one class 32 students yearly, B.S. Degree required as minimum. Salary dependent upon qualifications and experience, living accommodations available. Apply Director, Lutheran Hospital School of Nursing, 2609 Franklin Blvd., Cleveland 13, Ohio.

NURSING ARTS INSTRUCTOR & SCIENCE INSTRUCTOR: In approved School of Nursing in 190 bed General Hospital. One class admitted yearly, new nurses' residence, preparation with degree and teaching experience preferred. Salary open. Liberal personnel policies. Position available on or before August 15, 1954. Apply Director of Nursing, Bethesda Hospital, Zanesville, Ohio.

OBSTETRICAL SUPERVISOR: 225 bed general hospital, nationally accredited school, 75 students. Degree required or special preparation for teaching obstetrics. 40 hr. week and employee benefits. Apply Director of Nursing, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

OPERATING ROOM NURSES: Registered nurses for duty in an active operating room in a teaching hospital. Salary $247.50 plus bonus of $25 as soon as call is started. No previous OR experience necessary. Living quarters available. Write Director of Nurses, Cleveland City Hospital, Cleveland, Ohio.

OPERATING ROOM SUTURE NURSES: For new 144 bed hospital located in a friendly city of 93,000 at the gateway to Michigan's summer and winter resort areas. Air-conditioned operating suite of five fully equipped rooms. 40 hr. wk. Minimum starting salary of $270 to $370 per mo. including call. Excellent personnel policies. Opportunities for advanced professional educaton. Living accommodations available in the immediate vicinity. Personnel Director, St. Luke's Hospital, Saginaw, Mich.

PROFESSIONAL REGISTERED NURSES: For Staff and Supervisory capacities. 100 bed hospital in a beautiful summer resort area on Lake Huron. Staff Nurses, $275, Surgical Nurses, $297, Supervisors, $308 beginning salaries with $10 monthly differential for evening and night duty for a 40 hr. wk. Apply Director of Nursing. Alpena General Hopital, Alpena, Mich.

PROFESSIONAL REGISTERED NURSES: Supervising Nurse, $306.50 per mo., Professional Nurses, $291 per mo. Full maintenance, private room, new nurses' residence. 40 hr. week, sick leave, annual vacations, legal holidays. Operating room and staff positions open in 600 bed Tuberculosis Hospital. Excellent opportunity for experience in thoracic surgery. Staff positions in 2250 bed geriatric hospital. Hospitals located 22 miles from Chicago. Write or contact Administrator of Nurses, Oak Forest Institution, Oak Forest, Ill.

PSYCHIATRIC STAFF NURSE: For a private psychoanalytically oriented hospital, increasing staff to prepare for increase in bed capacity to 113. In-service program. 18 working days vacation, 15 working days sick leave, evening and night differential. Social Security. Beginning salary $300. Apply to Mr. Basil Cole, Peronnel Director, The Menninger Foundation, Topeka, Kans.

PUBLIC HEALTH NURSES: Vacancies in New York City Department of Health. Immediate appointment on provisional basis. Generalized service includes maternal and child care, school health and communicable disease control. Starting salary $3080. 37 hr. week, liberal vacation and sick time allowances, pension rights, in-service training. Applicants (except New York State veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth St., New York, N. Y.

PUBLIC HEALTH AND SCHOOL (a) School, public schools, faculty salary. Chicago area. (b) infirmary nurse, military academy, So. (c) Public health, foreign assignments, degrees, exp. req'd. (d) Women's college, beautiful campus overlooking Pac. Ocean. (e) School nursing consultant, State dept. W. RN9-7 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

PUBLIC HEALTH STAFF NURSES: For generalized program in County Health Dept., north San Joaquin Valley, Calif. 5 day, 40 hr. week. Salary $318 to $385 at 5th year. Car furnished. Vacation, sick leave, retirement and hospital insurance in effect. Certificate in Public Health Nursing and California driver's license required. For further information write George F. O'Brien, M. D., County Health Officer, P. O. Box 1607, Modesto, Calif.

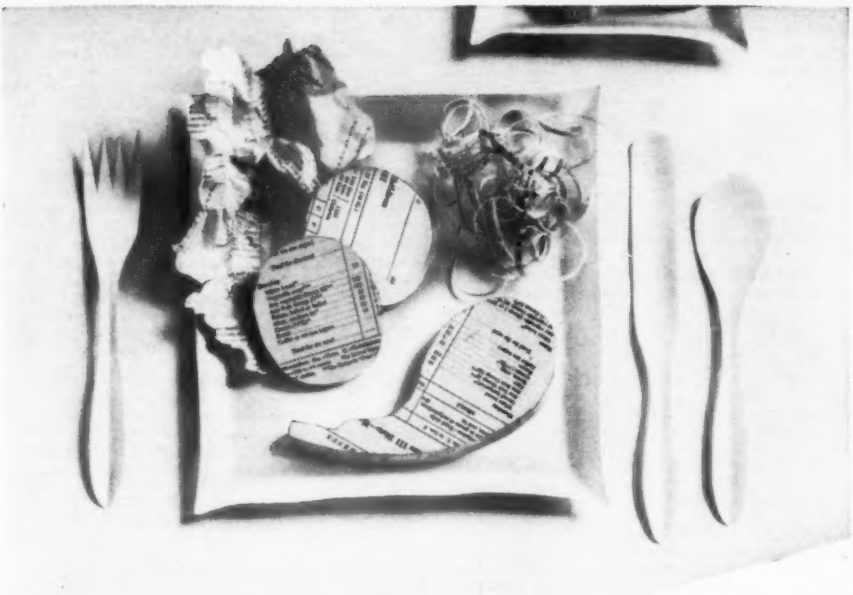
R.N.'s: 6 additional in 260 bed chronic disease home. $220 per mo. plus maintenance for daytime positions. $240 per mo. plus maintenance 12 midnight to 8 a.m. 5 day week. usual accruals and holidays. Automatic increases every six months. Pinehaven Nursing Home, Katherine H. Harris, R.N., Supervisor of Nurses, Pinewald, N. J.

R.N.'s: Under age 50. Beginning salary $310 per mo. $5.00 longevity increase every 6 mos for 3 years. Retirement plan, sick leave benefits, 11 holidays, 3 weeks vacation, 40 hr. week. New modern residence. State eligibility for California registration and submit photo to Director of Nurses, Tulare-Kings Counties Tuberculosis Hospital, Springville, Calif.

REGISTERED, GRADUATE OR PRACTICAL NURSES: Night or day. Deborah Sanatorium, Browns Mills, N. J.

REGISTERED NURSE: A wonderful opportunity to work with Christian young people. September through May. Private apartment in new infirmary. Eastern Baptist College, St. Davids, Pa.

REGISTERED NURSE ANESTHETIST: Tired of big city pressures? 135 bed general hospital in charming southern city of 18,000, short drive from Gulf of Mexico. Well qualified surgical staff. Salary range $380-$416 a month



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commensurate with experience. 4 weeks vacation with pay, sick leave, 2½ day weekend every 4th week. Apply Chief Anesthetist, John D. Archbold Memorial Hospital, Thomasville, Georgia.

REGISTERED NURSE ANESTHETISTS: 40 hr. wk., permanent positions open for surgery and obstetric departments. Liberal vacation and sick leave policies, Social Security, overtime pay. Extra pay for night duty. Automatic pay increases. Living accomodations available. Apply: Chief Nurse Anesthetist, Harper Hospital, Detroit 1, Mich.

REGISTERED NURSES: Needed by 140 bed Physical Medicine and Rehabilitation Hospital fully accredited by Joint Commission on Accreditation of Hospitals, treating patients with neuromuscular disabilities. Salary range $245 monthly to $285. In addition to salary complete maintenance provided in air-conditioned Nurses' quarters, plus pay differential for evening and night duty. Completely air-conditioned hospital is well located in relation to San Antonio, Austin and Gulf Coast. Delightful warm and dry winters. Contact the Administrator, Gonzales Warm Springs Foundation, Gonzales, Tex.

REGISTERED NURSES: For general duty in beautiful modern 45 bed hospital. Good salary with full maintenance. 44 hr. wk., automatic salary increase, retirement benefits. Apply D. D. Parke, Supt., Memorial Hospital, Belle Glade, Fla.

REGISTERED NURSES: A few positions for General Duty and Operating Room Nurses immediately available. Hospital fully accredited. Situated in pleasant suburban location, 8 mi. from Boston. Base rate of pay 40 hrs. Time and one-half for overtime. Average work week, 44 hrs. Automatic pay adjustments semi-annually for first 2 years. Increased pay for evening and night shifts. Social Security, retirement plan, sick leave, paid vacations, paid holidays. Living-in facilities available. Ample opportunity for advancement for qualified employees. Apply to Director of Nursing (in writing), The Waltham Hospital, Waltham, Mass., or call WAltham 5-1630.

REGISTERED NURSES: Two. For general duty, 24 bed hospital. Excellent salary, 2 weeks vacation, sick leave. Living accommodations available. Apply Business Manager, Karnes County Hospital, Karnes City, Tex.

REGISTERED NURSES: For new 144 bed hospital located in a friendly city of 93,000 at the gateway to Michigan's summer and winter resort areas. Staff and charge positions open. Salaries dependent upon educational background and experience with a minimum of $260 to $320 per mo. Monthly differential of $20 for afternoon duty and $15 for night duty. 40 hr. wk. Excellent personnel policies. Opportunities for advanced professional education. Accommodations available in the immediate vicinity. Personnel Director, St. Luke's Hospital, Saginaw, Mich.

REGISTERED NURSES: General duty, all shifts, in a new and beautifully equipped 72 bed general hospital located near Kentucky Lake area, town of 12,000 population. Beginning salary $270 for 44 hr. week, 40 hr. week optional. Regular increases, 2 weeks vacation, holiday and sick leave benefits. Differential for evening and night duty. Overtime paid at private duty rates. Apply Director of Nursing, Henry County General Hospital, Paris, Tenn.

REGISTERED NURSES: In progressive 250 bed fully approved hospital located in beautiful, exciting western city with ideal climate, mild winters. 5 day week, 40 hrs., starting salary $265 with automatic increase every 6 mos., of $100 per year, or $8.33 per mo. up to three years. $10 per mo. differential paid to those working afternoon and night shifts. Minimum wage scale for surgery nurses is $275. Write Superintendent of Nurses, Washoe Medical Center, Reno, Nev.

REGISTERED NURSES: For 150 bed hospital. 11-7 shift in Obstetrical Dept., as Supervisor, $275 per mo, plus $10 as no meal is furnished. Supervisor for night (11-7), $300 per mo., plus $10 as no meal is furnished. Two weeks paid vacation, 5 holidays per year. 44 hr. week. No laundry. Write Director of Nurses, Mrs. Maida F. Bailey, R.N., Plainview Hospital and Clinic Foundation, Plainview, Texas.

REGISTERED NURSES: For supervisory and General Staff positions. Liberal personnel policies. 40 hr. wk., Social Security and Blue Cross available. $20 monthly differential for 3-11 and 11-7 shifts. Apply Director of Nurses, Niagara Falls Memorial Hospital, Niagara Falls, N. Y.

REGISTERED NURSES: Salary scale $240 to $275 per mo. 40 hr. wk. Differential for evening and night duty, $17 per mo. Beginning salary based on length and recency of experience. Increases every 6 mos. Increases beyond the maximum on basis of merit. 2 wks illness allowance, 3 week vacation, opportunity for university study. Address inquiries to Director of Nursing, The Rochester General Hospital, Rochester 8, N. Y.

REGISTERED NURSES: Modern 43 bed hospital, general duty and supervisors. Good salaries with full maintenance. Apply Isabella N. Williams, Administrator, Suwannee County Hospital, Live Oak, Fla.

REGISTERED NURSES: For 165 bed hospital in residential suburb of Chicago. 40 hr. wk. Cash salary $230 for night duty, $225 evening duty and $215 day duty. $10 increase after 60 days and at regular intervals. Full maintenance in addition to salary includes single room in new nurses residence, plus meals and laundry. Low rental apartments for married nurses. Two to four weeks vacation, 6 holidays, sick time policy, free life insurance. Blue Cross Hospitalization. Leave of absence with full salary for post-graduate study granted to qualified nurses. Write Director of Nursing, MacNeal Memorial Hospital, Berwyn, Ill.

REGISTERED PROFESSIONAL NURSES: For supervisory, educational and general staff positions. Liberal personnel policies. 40

hr. week. Differential salary for evening, nights and operating room. Social Security. Christ Hospital, 76 Palisade Ave., Jersey City, N.J.

REHABILITATION NURSES: Prospective openings in a unique and challenging position requiring nurse counseling of seriously injured industrial workers through all phases of medical and rehabilitation programs. Recent graduates with B.S. Degree and some working experience desired. After preliminary training program, assignmnets will be made to branch offices in South, California and the Middle West. Travel with company car involved. Starting salary $3500 annually. Group Health and Insurance plans, 5 day week, paid vacations. Write W. S. Allan, Liberty Mutual Insurance Co., 175 Berkeley St., Boston, Mass., giving full resume of experience.

STAFF NURSES: Immediate openings. General duty. Nursing degree required. Openings with New Mexico State Welfare Department in two tuberculosis and two geriatric institutions. 44 hr. week. Salaries, $245 to $305. Annual leave and sick leave. Surgical Nurse: Salary, $260 to $325. Assistant Chief Nurse: Salary, $275 to $345. Apply to New Mexico State Welfare Department, Santa Fe, New Mexico.

STAFF NURSES: New staff nurse positions available in California. Must have California license or temporary permit. Registered nurses with no experience, $295-$341 month. One year graduate study or psychiatric experience will qualify for $310-$358. Salary increase after six months. Promotional opportunities, liberal vacation and retirement privileges. Write State Personnel Board, 1015 L. Street, Sacramento 14, Calif.

STAFF NURSES: For new 200 bed approved general hospital in residential suburb of Cleveland. Private rooms available in new residence on scenic site at shore of Lake Erie. New "square" hospital contains every known convenience for pleasant and efficient nursing. Starting monthly salary, $243 or $251 depending on experience; evening and night, $256 or $264. Increases at 3-6-12-18 months. Team assignment plan, non-rotating. Apply Director of Nursing, Euclid-Glenville Hospital, Euclid 19, Ohio

STAFF NURSES: For 458 bed Tuberculosis Hospital pleasantly situated about 20 miles from New York City. Beginning salary $271, increments $10 a mo. yearly to $321. $10 increase for evening or night duty. 40 hr. 5 day week with overtime for any work over 40 hrs. Liberal vacation holidays and sick time. Full maintenance available at $52 a month. Pension Plan. Apply Supt. of Nurses, Essex County Sanatorium, Verona, N. J.

STAFF NURSES: All services. 125 bed general hospital. No school. Organized medical staff. Apply to Director of Nursing, Archbold Memorial Hospital, Thomasville, Ga.

STAFF NURSES: New staff nurse positions in July and August. Must have California license or temporary permit. Registered nurses with no experience, $295-$341 month. One year graduate study or psychiatric experience will qualify for $310-$358. Salary increase after six months. Promotional opportunities, liberal vacation and retirement privileges. Write State Personnel Board, 1015 L Street, Sacramento 14, Calif.

STAFF NURSES: Wide clinical experience. 40 hr. week. Starting salary $280 mo. Please write for further details to Department of Nursing, University Hospital, Ann Arbor, Mich.

STAFF NURSES: For 45 bed general hospital, completely remodeled and new equipment. 44 hr. week. Starting salary $250 up. Good working conditions. Liberal personnel policy. Apply Administrator, Coon Memorial Hospital, Dalhart, Tex.

STAFF & OPERATING ROOM NURSES: New 104 bed general hospital. Latest equipment, ideal location banks of St. Joseph River, heart of fruitbelt, Lake Michigan shores. Living accommodations available. Jr. College in area. 2 hrs from Chicago. 40 hr. week, basic salary $234, shift bonus, good personnel policies, friendly community. Details write Nursing Director, Memorial Hospital, St. Joseph, Mich.

STAFF NURSES — OPERATING ROOM NURSES: For modern 650 bed tuberculosis hospital affiliated with Western Reserve University and approved by joint commission on accreditation of hospitals. 40 hr. 5 day wk. Salary $293-$323 with automatic increases. Full maintenance available at minimum rate. Housing for 2 or more nurses. Advancement for eligible applicants. Meets approved minimum employment standards of The State Nurses' Association. Apply Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

STAFF & SURGICAL: (a) Two. surg. two staff, small gen'l hosp. resort town, San Joaquin Valley. (b) New hosp. 300 beds, recently completed, affil. important group, univ. center, So. (c) Staff, new gen'l hosp. 100 beds, one of larger towns, Alaska. (d) Gen'l 300 bed hosp., res. area, overlooking Lake Mich. Staff, straight days, $296, surg. $335. RN9-8 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

SUPERVISOR: B. S. Degree in Public Health Nursing, V.N.A. experience. Salary open. Write Mrs. Catherine Beermann, Executive Director, Visiting Nurse Ass'n., 3798 Grand Ave., Oakland 10, Calif.

SUPERVISORS: (a) All depts., new hosp. 300 beds, unit univ. group. Oppor. continuing studies, W. (b) O.R. New hosp. air-conditioned, excellently equipped. 12 cases daily. Coll. town, delightful section, S. C. (c) OB. Gen'l 250 bed hosp. univ. town, MW. $4500. (d) Thoracic Surg. new dept. 400 bed hosp. affil. univ. educ. opport. E. (e) Ped. & Psy. New 550 bed gen'l hosp. affil. med. school, SW. (f) Supervisors & Head Nurses, med, OB, Ortho, Surg. Ped. Large teaching hosp. Lge city, MW. (g) OR. Lge. teaching hosp., dept. in new wing, med center, E. RN9-9 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

SURGICAL NURSE: For small hospital. Good salary plus full maintenance. Apply White Pine General Hospital, Ely, Nev.

[Turn the page]

SURGICAL NURSES: For 165 bed hospital in residential suburb of Chicago. 40 hr. duty after September 1, 1953. Cash salary $230. Full maintenance in addition to salary includes single room in new nurse's residence plus meals and laundry, which is equivalent to $350 per mo. Low rental apartments for married nurses, and $25 additional salary rate for nurses living in their own homes. $10 increase after 60 days and at regular intervals. Two to four weeks vacation, 6 holidays, sick time policy, free life insurance, Blue Cross Hospitalization available. Remuneration for call. Leave of absence with full salary for post-graduate experience. Write Director of Nursing, MacNeal Memorial Hospital, Berwyn, Ill.

X-RAY TECHNICIAN: 44 hr. week, 2 weeks vacation with pay plus 7 paid holidays per year. Good salary with full maintenance. Private room in a beautiful nurses' home. We are 115 bed General Hospital located 35 miles from New York and are served by the DL&WRR and the Greyhound Bus Line. Apply Dover General Hospital, Jardine St., Dover, N. J.

ADMINISTRATORS: (a) Well endowed foundation, 40 beds, expand'g to 100, especially recomm'd. New England. (b) 50 bed gen'l hosp. About $6000. Nr. univ. med center, MW. (c) Vol. gen. hosp. 65 beds, attrac sm twn, NW. (d) R.N. w/psych. exp. 30 bed psy. hosp. $5200 and full mtce. MidE. (e) Home for elderly people. In no sense is this an institution nor are any of residents inmates. Total 75. 15 empl. good sal., nice apt., 1 mo. summer vac. Extremely desirable city. Pac. NW.

ANESTHETISTS: (a) Sm vol gen hosp., no OB call. 2 Bd. surgeons. $6000, full mtce, warm climate. (b) Gen. hosp. 250 beds. $6000 plus full mtce. Twn 50,000 ½ hr. lge city, univ. med. center, Pa. (c) Vol gen hosp 300 beds, good sal, city 175,000, Mich. (d) Sm gen vol hosp., 2 other anes empl, famous resort twn, Fla. (e) Grp 15 distinguished specialists. $7200. Minimum call. Lovely coll. twn nr. univ. med center, MW. (f) Vol gen hosp 300 beds, substantial sal. plus 50% of chges after hrs. Should net $7-8000. Especially recommended, lge univ city, S. (g) Vol gen'l hosp. over 300 beds, island in the Pacific, extremely desirable city.

DIRECTOR OF NURSES: Dir. of Nurs. Ed. 4 yr. degree prog., impor. med. sch. $6000, W. (b) Nurs. Serv. & Ed. Expand'g 250 bed gen'l hosp. Sch temp NLNE accred., excel sal, 3 rm suite avail., E. (c) Supervisory R.N., sm gen hosp., good sal, Calif. (d) Gen hosp 135 beds, new bldg., attrac coll city 25,000, MW. (e) TB hosp. 200 beds, $6500, full mtce, nice

apt., MidE. (f) Nurs. serv. only, 110 bed vol. gen. hosp. attrac res twn, E. (g) Nurs serv & ed., very lge teach'g hosp., full faculty rank, univ. med center, MW. (h) Nurs serv only, gen hosp. 100 beds, attrac coast resort area, Pacific NW.

FACULTY POSTS: (a) Ed dir-nurs arts instr. sch of 36 students affil univ. med staff, gen hosp 140 beds, new bldg. To $5400, N. Y. State. (b) Ed. dir. expansion prog will double size of sch. Now have 85 students. Min $5400 & full mtce. 329 bed gen hosp, S. (c) Science instr., 45 students, 250 bed vol gen hosp. To $4800, attrac twn 40,000 MW. (d) Nurs arts instr. 200 bed gen. vol. hosp., gd sal, Bay area. (e) Clin instr., 67 students. Excl. med staff. 150 bed gen. hosp. To $5000 & full mtce. Twn nr. 2 univ. med centers, Mid E.

OFFICE, CLINIC, SCHOOL: (a) Health clinic, famous resort area. $300 and full mtce, MW. (b) Well staffed office of busy internist. Minimum $300, res. suburb of Los Angeles. (c) School, resp. for hlth prog of 75 children, kindergarten to H.S. & 32 adults, sm infirmary, sal & living for 9 mos. Pac NW.

PUBLIC HEALTH: (a) Health super & social dir., full chge, health & social programs, 126 students, gen hosp. 300 beds, desirable city nr univ med center, E. (b) P.H. coordinator, teach course in PH nurs & "social problems in nursing serv", fully approv'd 375 bed gen hosp univ city, Mid E.

SUPERVISORS: (a) OR. Teach'g hosp. $6000, univ. med. center, Pac, NW. (b)OB, vol gen hosp 200 beds. To $4000, res. suburb Chgo. (c) Ped. for new div. of 11 beds, new wing 200 bed gen hosp, Calif. (d) OR, exp'd, chest surg., new depts. thoracic surg. & X-ray, TBc hosp 400 bed, oppty continue educ nearby med schl. Minimum $4000. (e) Nite & evening, new 450 bed hosp. Minimum $4000, res suburb univ med center, MidE.

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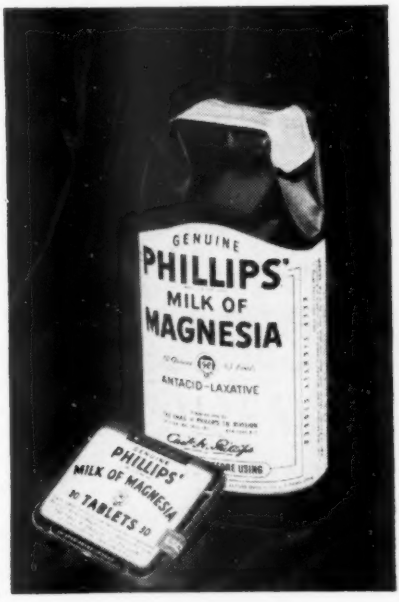

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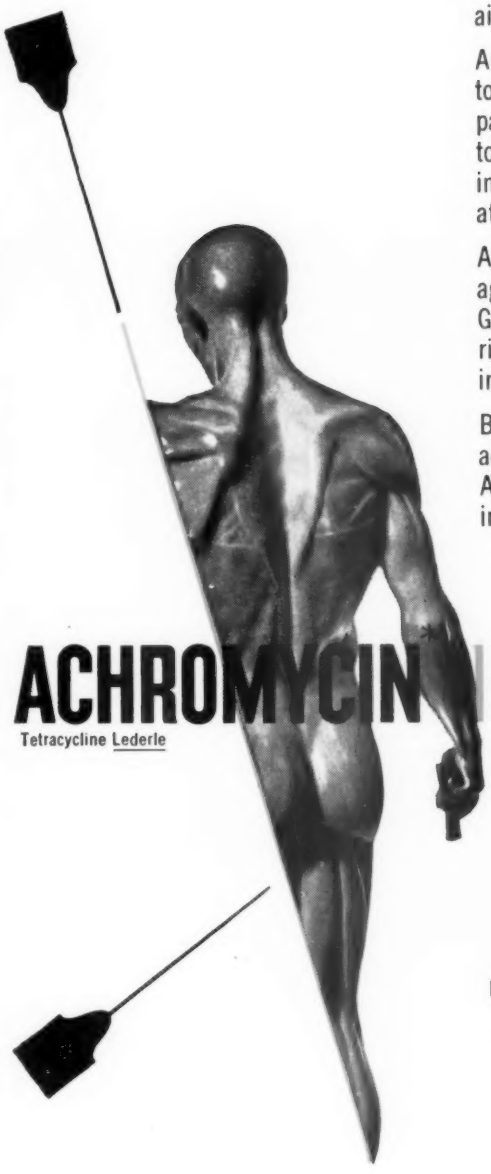

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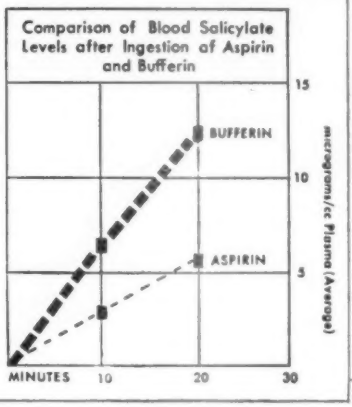

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Bufferin's antacid ingredients protect the stomach against aspirin irritation. This has been clinically demonstrated on hundreds of patients.

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1. Effect of Buffering Agents on Absorption of Acetylsalicylic Acid. J. Am. Pharm. Assoc., Sc. Ed. 39:21, Jan. 1950

2. Gastric Tolerance for Aspirin and Buffered Aspirin. Ind. Med. 20:480, Oct. 1951

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